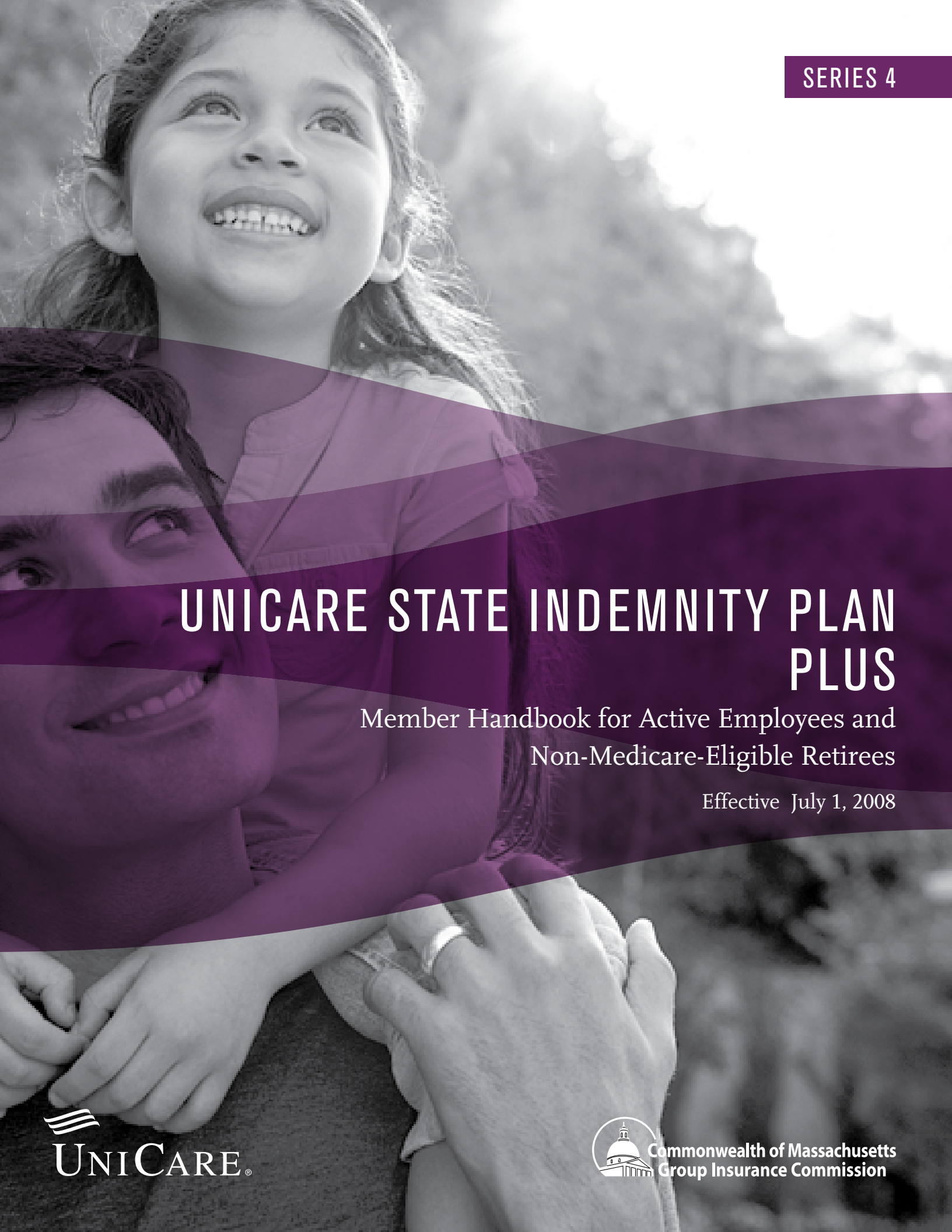

SERIES 4

UNICARE STATE INDEMNITY PLAN PLUS

Member Handbook for Active Employees and Non-Medicare-Eligible Retirees

Effective July 1, 2008

UniCare®

Commonwealth of Massachusetts
Group Insurance Commission

Part 1: Medical Plan

Important Telephone Numbers (toll free)

UniCare State Indemnity Plan/PLUS
(800) 442-9300
TDD: (800) 322-9161

Express Scripts
(877) 828-9744
TDD: (800) 842-5754

United Behavioral Health
(888) 610-9039
TDD: (800) 842-9489

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Handbook is a guide to benefits for you and your covered dependents under the UniCare State Indemnity Plan/PLUS (the PLUS Plan). These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for people insured through the GIC. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for the UniCare State Indemnity Plan/PLUS such as claims processing, customer service, utilization management and medical case management at its Andover Service Center in Andover, Massachusetts. UniCare is not the fiduciary or the insurer of the PLUS Plan.

Throughout this Handbook, the UniCare State Indemnity Plan/PLUS is referred to either by its full name, as the "PLUS Plan" or as the "Plan." The Group Insurance Commission is referred to by its full name or as the "GIC."

To fully understand your benefits, please read this Handbook carefully.

How This Handbook Is Organized

Descriptions of the benefits available to you and your covered dependents are provided in the following three parts of this Handbook.

Part 1: Medical Benefits

This part of the Handbook describes the benefits available under the PLUS Plan for medical services, treatment and supplies. These benefits are administered by **UniCare**. See page 2.

Part 2: Prescription Drug Plan

This part of the Handbook describes the prescription drug benefits, which are administered by **Express Scripts**. See page 67.

Part 3: Mental Health, Substance Abuse and Employee Assistance Programs

This part of the Handbook describes the mental health, substance abuse and Employee Assistance Programs of the PLUS Plan, which are administered by **United Behavioral Health (UBH)**. See page 77.

If you have questions about any of your benefits, please refer to the contact information on page 6.

About Your Medical Plan

The PLUS Plan provides comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. It is important to keep in mind that benefits differ depending on the provider or the service and that not all services are covered under the Plan.

The PLUS Plan offers you a network of physicians and hospitals throughout Massachusetts, Connecticut, Maine, New Hampshire and Rhode Island. As a member of the PLUS Plan, you are not required to choose a primary care physician and you do not need a referral to see a specialist. The following table shows the advantages of using PLUS providers for your health care.

If you need to see a provider, including a specialist, the provider must be in the PLUS network for you to receive the highest level of benefits under the Plan. To make sure a provider participates in the PLUS network, check the printed PLUS Provider Directory, or access the Plan's online directory at www.unicarestateplan.com. You can also call Customer Service at (800) 442-9300.

PLUS Providers When you receive covered care from a PLUS physician, PLUS hospital or other PLUS provider	**Non-PLUS Providers** When you receive covered care from a physician, hospital or other health care provider that is not a PLUS provider
▪ You receive network level benefits so your share of the cost is lower. ▪ You pay copayments at the time of the service. ▪ **Massachusetts PLUS Providers Only:** You don't have to call the Plan before a hospital stay or before receiving any other type of care; your Massachusetts PLUS provider will do it for you. (For PLUS providers outside Massachusetts, you are responsible for notifying the Plan; otherwise, your benefits may be affected.) ▪ You have no claims to file.	▪ You receive non-network level benefits, so you pay a larger portion of your medical bills. ▪ You meet all copayments and deductibles first, and you also pay a percentage of most medical bills. ▪ You have to call the Plan to notify of hospital admissions and certain other types of care; otherwise, your benefits may be reduced. ▪ You may have to file claims from some providers.

How to Receive the Highest Level of Benefits from Your Medical Plan

Please read the following information carefully to ensure that you receive the maximum level of Plan benefits for medically necessary services.

- **In Massachusetts:** Use PLUS providers for hospital and physician services. For a comparison of benefits when you use PLUS providers versus non-PLUS providers, refer to the Benefit Highlights section.

  You'll also save on out-of-pocket costs for physician office visits when you use PLUS Tier 1 or Tier 2 physicians in Massachusetts—those who have demonstrated quality and/or cost-efficiency in their practices. To find out which tier your physician is in, log onto the Plan's web site: www.unicarestateplan.com and click on physician tier listings under "Find a Provider." Then select the link for the PLUS Plan. You can also check the printed PLUS Directory or call the Andover Service Center at (800) 442-9300 for assistance. For more information on physician tiering, see page 12 in the Your Costs section of this Handbook, or visit www.unicarestateplan.com.

- **For Residents of Connecticut, Maine, New Hampshire and Rhode Island:** PLUS members living in these states also have access to PLUS providers in their state. When you use these providers, you receive the same coverage as you would with Massachusetts PLUS providers. You are responsible for meeting the Plan's managed care notification requirements when you use providers other than Massachusetts PLUS providers. To locate PLUS providers in Connecticut, Maine, New Hampshire or Rhode Island, log onto www.unicarestateplan.com. Click on "out-of-state network providers only" under "Find a Provider" and follow the directions provided.

- **When You Travel:** When you travel outside your home state, you have access to UniCare's Travel Access providers for urgent care—except for mental health/substance abuse providers. Our Travel Access providers agree not to balance bill you for charges above the Plan's allowed amount. Student dependents who attend school full time in states other than Massachusetts also have access to UniCare's Travel Access providers. It is important for you and your dependent to use these providers while outside Massachusetts so you won't be balance billed for your care. You are responsible for meeting the Plan's managed care notification requirements when you use providers other than Massachusetts PLUS providers. To locate a Travel Access provider when you travel, log onto www.unicarestateplan.com. Click on "out-of-state network providers only" under "Find a Provider" and follow the directions provided. Or call Customer Service at (800) 442-9300 for assistance.

- The Andover Service Center must be notified at (800) 442-9300 for **all hospital admissions** and for certain selected outpatient procedures and services. The **telephone symbol** you see throughout this Handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Andover Service Center within the specified time frame. Failure to do so will result in a reduction in benefits of up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states). Please refer to the Managed Care section of this Handbook for specific notification requirements and responsibilities. You'll also find details regarding what information you need to provide when you call the Plan to give notification of an admission or service.

- You can also use PLUS providers for the following services to enhance your level of benefits:

  — outpatient laboratory services
  — durable medical equipment
  — medical/diabetic supplies
  — home health care
  — home infusion therapy

  For lists of PLUS providers, log onto the Plan's web site: www.unicarestateplan.com, or call the Andover Service Center at (800) 442-9300.

- Carry your UniCare State Indemnity Plan ID card with you at all times and always show it when you go for care. This enables your provider to confirm your eligibility for Plan benefits.

Online Access to Medical Information and Plan Resources at www.unicarestateplan.com

For your convenience, you can access a broad range of Plan-related and general health care information, as well as helpful tools on the PLUS Plan's web site: www.unicarestateplan.com.

The **computer symbol**  that you see throughout this Handbook indicates that information on the highlighted topic is available on the Plan's web site: www.unicarestateplan.com.

Our comprehensive web resources give you the ability to:

- **Manage and improve your health with tools and information provided through Healthy Living, powered by *Web*MD®**. It includes health assessments, links to health articles, product alerts and recalls. This resource also offers interactive online programs allowing you to access items such as tracking tools for your diet, fitness, weight management and medication needs.
- **Get help from the Healthcare Advisor℠** with making reliable decisions about physicians, hospitals and treatments so you can confidently manage your health care. The Healthcare Advisor provides extensive health care information designed to help Plan members understand and manage various health conditions, treatments and procedures. This resource also provides profiles of health care facilities to help members assess where to best receive care, based on their needs and preferences.
- **Locate providers**, including PLUS providers and UniCare's Travel Access and out-of-state network providers. You can also check to see which tier your physician is in.
- Get convenient, secure access to **information about your claims**.
- Check out the Plan's **discounts on health-related products and services** available through the HealthyExtensions℠ Program.
- **E-mail the Plan or order Plan materials**, such as ID cards and Member Handbooks.
- **View Plan documents**, including your Member Handbook, any Benefit Updates to your Handbook and other Plan information.

MedCall Health Information Phone Line

The PLUS Plan's MedCall program provides a 24-hour, toll-free number to access nurse counselors who can answer your questions about procedures or symptoms that you would like to discuss. Nurse counselors can provide information about appropriate care settings and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. MedCall also serves as a referral source for local, state and national self-help agencies. To speak with a nurse counselor, call the MedCall toll-free number, (800) 424-8814. You will need to provide the following Plan-specific code: 1002.

By calling the above number, you can also access MedCall's library of more than 200 audio tapes to get automated information over the phone on many health-related topics. To view the list of available audio tapes, log onto www.unicarestateplan.com.

Overview

This section gives you important information about the PLUS Plan, including:

- the Andover Service Center and how its staff can help you
- the process for ordering new identification cards when needed
- how to access a language interpreter when speaking with a customer service representative at the Andover Service Center
- contact information when you have questions about your medical plan, your prescription drug plan or your mental health, substance abuse and Employee Assistance Programs
- the Plan's Notice of Privacy Practices

The Andover Service Center

The Andover Service Center is where UniCare administers services; processes claims; and provides customer service, utilization management and medical case management for the medical component of the PLUS Plan. Representatives are available Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. to answer questions you and your family may have about your medical coverage. You can also access claims information 24 hours a day, seven days a week from our automated telephone line, or from the Plan's web site: www.unicarestateplan.com.

When you call the Andover Service Center, you will speak with customer service representatives or patient advocates, depending on the nature of your call.

Customer service representatives are benefits specialists who can answer questions about:

- claim status
- notification requirements
- covered services
- PLUS providers
- Plan benefits
- resources on the Plan's web site: www.unicarestateplan.com

Patient advocates are registered nurses who can help you coordinate your health care needs with the benefits available under the Plan. The patient advocate will:

- provide information about the Managed Care Program, including Utilization Management, Medical Case Management, and Quality Centers and Designated Hospitals for Transplants
- answer questions about the Plan's coverage for hospital stays and certain outpatient benefits
- speak with you and your physician about covered and non-covered services to help you obtain care and coverage in the most appropriate health care setting and let you know what services are covered, and
- assist you with optimizing benefits for covered services after you are discharged from the hospital

Your Identification Card

When you are enrolled in the PLUS Plan, you will receive an identification (ID) card. Be sure to present your ID card when you seek medical care. Your card contains useful information about your benefits and important telephone numbers you and your doctor may need.

If you lose your ID card or need additional cards, you can order new cards from the Plan's web site at www.unicarestateplan.com. You can also call the Andover Service Center at (800) 442-9300.

Interpreting and Translating Services

If you need a language interpreter when you contact the Andover Service Center, a customer service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you are deaf or hard of hearing and have a TDD machine, you can contact the UniCare State Indemnity Plan/PLUS by calling its telecommunications device for the deaf (TDD) line at (800) 322-9161 or (978) 474-5163.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The GIC keeps the health and financial information of current and former members private, as required by law. This notice also explains your rights as well as the GIC's legal duties and privacy practices. The GIC's policies comply with the Health Insurance Portability and Accountability Act (HIPAA), which was signed into federal law in August 1996 to help improve the efficiency of the health care system in the United States.

The GIC's Notice of Privacy Practices is contained in Appendix A at the back of this Handbook. Please read this notice carefully.

Important Contact Information

If you have questions, please contact the following:

For information about your medical benefits:
UniCare State Indemnity Plan/PLUS
P.O. Box 9016
Andover, MA 01810-0916
(800) 442-9300
TDD: (800) 322-9161
www.unicarestateplan.com

For information about your prescription drug plan:
Express Scripts
(877) 828-9744 (toll free)
TDD: (800) 842-5754
www.express-scripts.com

For information about your mental health and substance abuse benefits:
United Behavioral Health
(888) 610-9039 (toll free)
TDD: (800) 842-9489
www.liveandworkwell.com
(access code: 10910)

Overview

This section describes the costs that you may be responsible for paying in connection with services covered by the Plan. These costs include copayments, deductibles and coinsurance. This section also explains how the Plan reimburses health care providers and provides information about physician tiering and using non-Massachusetts providers.

Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for a covered dependent. The deductible amounts you must satisfy are shown in the chart on this page.

Individual Calendar Year Deductible

The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In the PLUS Plan, you only have an individual calendar year deductible when you use non-PLUS providers.

For example: If you go to a **non-PLUS** provider for a medical problem in January, you will have to pay the office visit copay and then $100 of the allowed amount. If your provider charges less than $100, the balance of the deductible will be taken from your next visit. If there are remaining charges after the deductible, then the Plan pays 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the $100 calendar year deductible, you will not have to pay it again for the remainder of the year, regardless of the types of services you receive.

The Plan determines the providers to whom you owe the deductible based on the order the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe deductible amounts for any services you receive from non-PLUS providers.

Deductibles	When You Use a PLUS Provider	When You Use a Non-PLUS Provider
Individual Calendar Year Deductible	None	$100
Family Calendar Year Deductible	None	$200
Inpatient Hospital Quarterly Deductible[1]	Tier 1: $250[2] Tier 2: $400[2]	$400[2]
Select Complex Procedures/High-Risk Maternity Care at a Designated Hospital[3]	$250 (when you use a designated PLUS Tier 2 hospital)	$400[2]
Quality Centers and Designated Hospitals for Transplants[4]	$250 (when you use a PLUS Tier 1 hospital or a PLUS Tier 2 hospital that is a Quality Center or Designated Hospital[4]) $400 (when you use any other PLUS Tier 2 hospital)	$250 (when you use a Quality Center or Designated Hospital[4]) $400 (when you use a non-PLUS hospital that is not a Quality Center or Designated Hospital[4])
Outpatient Surgery Quarterly Deductible	$100	$100

1 The inpatient hospital quarterly deductible is waived for readmissions that occur within 30 days following a hospital discharge, within the same calendar year.

2 To find out which hospitals have a $250 inpatient deductible and which have a $400 inpatient deductible, see Appendix C at the back of this Handbook.

3 For a list of these procedures and hospitals, see Appendix D.

4 To find Quality Centers and Designated Hospitals for Transplants, please call the Andover Service Center and ask to speak with a case manager.

Some of the types of charges the calendar year deductible applies to are office visits and outpatient hospital services. The calendar year deductible does not apply to preventive care visits, laboratory tests and x-rays or to any service provided by a PLUS provider. Check the Benefit Highlights section to see where the calendar year deductible is applied.

Family Calendar Year Deductible

If you have family coverage and use non-PLUS providers, a deductible will apply to your family in any calendar year. There is no family calendar year deductible when you use PLUS providers.

For Example: You, your spouse and your three children have family coverage under the PLUS Plan. You and two of your children go to non-PLUS providers for medical care in January. Two of you pay $75 deductibles and one of you pays a $50 deductible. Even though no one in the family has met the $100 individual deductible, because the family deductible of $200 has been met, no additional calendar year deductible will apply to your family.

Deductible Carryover

Any amounts you pay toward the individual calendar year deductible in the last three months of a calendar year will be applied toward the deductible for the next calendar year. Carryover does not apply to the inpatient hospital quarterly deductible.

Inpatient Hospital Quarterly Deductible

The inpatient hospital quarterly deductible applies on a per-person, per-calendar year quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any single calendar year quarter, he or she will not have to satisfy the deductible again during that same calendar year quarter. In addition, the inpatient hospital deductible is waived for readmissions that occur within 30 days following a hospital discharge within the same calendar year (even if the admissions occur in different calendar year quarters). This deductible does not apply toward the calendar year deductible.

For example: If you are admitted to a PLUS hospital in January and stay overnight, you will be responsible for paying the inpatient hospital deductible. If you are readmitted to a PLUS hospital in March, you will not be responsible for another inpatient hospital deductible, as March is in the same calendar quarter as January. However, if you are readmitted to a PLUS hospital in May, you will incur another deductible.

Example 2: If you are admitted to a PLUS hospital at the end of March and then readmitted in April (within 30 days of your March discharge), you will not be responsible for another deductible. But if you are readmitted to a PLUS hospital in May (more than 30 days from your March discharge), you will incur another deductible.

Example 3: If you are admitted to a PLUS hospital at the end of December and then are readmitted in the beginning of January, you will be responsible for another deductible because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

Outpatient Surgery Quarterly Deductible

The outpatient surgery quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent has surgery at a hospital or a freestanding surgical facility, you are responsible for paying this deductible. However, once a covered person satisfies the outpatient surgery quarterly deductible in any calendar year quarter, he or she will not have to satisfy this deductible again during that same calendar year quarter. This deductible does not apply toward the calendar year deductible.

For example: If you have outpatient surgery at a hospital in January, you will be responsible for paying the outpatient surgery deductible on the hospital charges. If you have another surgery in March, you will not have to pay another outpatient surgery deductible as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another outpatient surgery deductible.

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the provider, the type of service you receive and the tier level of the physician. Copays are always deducted before the individual calendar year deductible is applied (where applicable). Copays do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

For example: If you are a member of the PLUS Plan and you or a covered dependent go to a physician's or chiropractor's office, you or your dependent will be responsible for paying an office visit copay.

Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the emergency room copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly deductible applies.

Copays for Medical Services

The chart below shows the copays you are responsible for with certain types of medical services. (Please note that you are not required to select a primary care physician.)

Type of Medical Visit	Copay (when you use a PLUS provider)	Copay (when you use a non-PLUS provider)
Emergency Room Visit	$50	$50
Physician Office Visits:		
Tier 1:		
▪ Primary care physicians*	$10	$10
▪ Specialty care physicians	$15	$15
Tier 2:		
▪ Primary care physicians*	$20	$20
▪ Specialty care physicians	$20	$20
Tier 3:		
▪ Primary care physicians*	$25	$25
▪ Specialty care physicians	$35	$35
Physical Therapy and Occupational Therapy	$15	$15
Chiropractic Care	$15	$15
Routine Eye Examinations	**With an Optometrist:** $20 **With an Opthalmologist:** see physician office visit copays above	

*Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

You can also see the following providers at the same copay level as Tier 2 providers:

- All non-Massachusetts physicians
- Physicians listed in the PLUS Directory with the indication that they do not have sufficient data available to allow us to determine any type of scoring—such as those physicians who are new to practice
- Nurse practitioners and physician assistants

Coinsurance

Coinsurance is the percentage of the allowed amount that you must pay for covered services after any applicable copay or deductible is satisfied. For example, if the Plan pays 80% of the allowed amount for certain services, you are responsible for paying the remaining 20%. To see which benefits coinsurance applies to, refer to the Benefit Highlights section. In addition, you may be responsible for the difference between the allowed amount and the provider's charge for services received from providers outside of Massachusetts if you do not use PLUS providers or UniCare's Travel Access providers.

Out-of-pocket Maximum

To protect you from large medical expenses, the Plan limits the amount of coinsurance you pay out-of-pocket each year for certain covered services. This out-of-pocket maximum applies to each covered person, as follows:

PLUS Provider	Non-PLUS Provider
$750	$3,000

Once you reach the out-of-pocket limit, the Plan pays 100% of the allowed amount for the designated covered services for the rest of the calendar year.

The following out-of-pocket expenses do not apply toward your out-of-pocket maximum:

- Deductibles
- Copayments
- Certain coinsurance amounts (to find out which coinsurance amounts do not apply toward the out-of-pocket maximum, see the Benefit Highlights section)
- Amounts in excess of the Plan's allowed amounts
- Amounts for non-covered services

If you are using PLUS providers, the only medical costs that apply toward the out-of-pocket maximum are home health care, prostheses, braces and other covered medical services such as allergy serum.

Reasonable and Customary Charge

Charges for covered services are reasonable and customary to the extent that they do not exceed the general level of charges for like or similar treatment, services or supplies by other providers in the area where the charges are incurred. Charges in excess of the Reasonable and Customary Charge are not considered for payment under the Plan.

Reasonable and Customary Allowed Amount

The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

The PLUS Plan has established Reasonable and Customary Allowed Amounts for most services from providers. This allowed amount may not be the same as the provider's actual charge.

Charges Over the Reasonable and Customary Allowed Amount

Whether located within or outside of Massachusetts, PLUS providers are contracted to accept the Plan's allowed amount. Therefore, they cannot balance bill you for any charges exceeding the allowed amount determined by the Plan.

In some cases, a non-PLUS provider may bill you for charges over the allowed amount. The Plan will not consider these charges for payment.

Massachusetts Providers

Under Massachusetts General Law, Chapter 32A: Section 20, providers who render services in Massachusetts are prohibited from billing you for the amount in excess of Plan determined or allowed amounts. If you receive a bill for charges above the allowed amount from a Massachusetts provider, contact the Andover Service Center to help you resolve this issue.

Non-Massachusetts Providers

These providers may balance bill you for the difference between the payments made by the Plan, based on the Plan's allowed amount and the full amount the provider charged. The charges in excess of the Plan's allowed amounts will not be considered for payment by the Plan.

- **For Residents of Connecticut, Maine, New Hampshire and Rhode Island:** PLUS members living in these states also have access to PLUS providers in their state at the same benefit level as when they use Massachusetts PLUS providers. If you receive a bill for charges above the allowed amount from a PLUS provider, contact the Andover Service Center to help you resolve this issue. You are responsible for meeting the Plan's managed care notification requirements when you use providers other than Massachusetts PLUS providers. When you use these providers, please show your UniCare out-of-state ID card.
  To locate PLUS providers in Connecticut, Maine, New Hampshire or Rhode Island, log onto www.unicarestateplan.com. Click on "out-of-state network providers only" under "Find a Provider" and follow the directions provided.
- **When You Travel:** When you travel outside your home state, you have access to UniCare's Travel Access providers for urgent care—except for mental health/substance abuse providers. Travel Access providers agree not to balance bill you for charges above the Plan's allowed amount. Student dependents who attend school full time in states other than Massachusetts also have access to UniCare's Travel Access providers. It is important for your dependent to use these providers while outside Massachusetts so you won't be balance billed for his or her care. You are responsible for meeting the Plan's managed care notification requirements when you use providers other than Massachusetts PLUS providers. When you use Travel Access providers, please show your UniCare State Indemnity Plan ID card.

  For a list of providers available to you when you are traveling outside of Massachusetts, please check the online provider finder at www.unicarestateplan.com. Click on "out-of-state network providers only" under "Find a Provider" and follow the directions. The provider finder will help you identify UniCare's Travel Access providers that will not balance bill you for your care.

Important: If you need mental health/substance abuse treatment or the Employee Assistance Program (EAP), you must contact United Behavioral Health (UBH), the administrator for these services. You will be subject to balance billing if you use a mental health/substance abuse provider that is not in the UBH network. (For more information, see page 77–92.)

Provider Reimbursement

The PLUS Plan reimburses providers on a fee-for-service basis. The Plan does not withhold portions of benefit payments from providers, nor offer incentive payments to providers related to controlling the utilization of services. Explanations of provider payments are detailed in your Explanations of Benefits (EOBs). Under the Plan, providers are not prohibited from discussing the nature of their compensation with you.

Physician Tiering

Physician tiering is part of the Group Insurance Commission's Clinical Performance (CPI) Initiative to improve quality and control premium increases while continuing to offer a comprehensive level of benefits and a wide choice of providers.

Massachusetts physicians are assigned to tiers based on an extensive evaluation of both their quality and cost-efficiency. Based on the scores on both of these measures, which are developed with reference to their peers in the same specialties, individual physicians are assigned to one of three tiers:

- **Tier 1 (excellent)** – Physicians who exceed the high mark for quality established by the Plan, and who are more cost efficient, are assigned to Tier 1. Tier 1 is designed to acknowledge the high performance of these physicians for both quality and cost-efficiency, as determined by the available data. These physicians are rated as "excellent."
- **Tier 2 (good)** – Tier 2 includes physicians who have demonstrated good practice patterns but who have not achieved the results in quality and/or cost-efficiency that are necessary to qualify for Tier 1. These physicians are rated as "good."
- **Tier 3 (standard)** – Physicians in this tier have scored below the standard of performance in quality, cost-efficiency or both. For the same types of conditions, compared to their peers, these physicians are more expensive, and/or their patients are not receiving an optimum level of care according to evidence-based quality guidelines. These physicians are rated as "standard."

You will find detailed explanations about the assignment of doctors to tiers and about the methods used to determine the efficiency and quality scores of the physicians at www.unicarestateplan.com under "Forms and Documents." You can also call the Andover Service Center at (800) 442-9300 to request materials.

The methodology used in this tiering process relies on nationally accepted approaches to evaluating both quality and efficiency, and uses claims data submitted by health care providers themselves. The use of claims data has some limitations, and there are additional methods that you may wish to use in evaluating the quality and efficiency of providers. In making decisions about choosing your providers, you should consider the potential limitations in the data as well as other factors that correlate with the quality of care that you receive, some of which may be subjective in nature, but which are important to you.

How to Find out Your Physician's Tier Designation

To find out which tier your physician is in, log onto the Plan's web site: www.unicarestateplan.com; under "Find a Provider," click on the link for physician tier listings and select the link for PLUS Plan. You can also check the printed PLUS Directory or call the Andover Service Center at (800) 442-9300 for assistance.

Overview

This section provides information on how to submit a claim, how your benefits are covered when you have coverage under more than one health plan, how to view your claims online, your appeal rights under the Plan, and other important information relating to your claims.

How to Submit a Claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, physicians or other health care providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must include written proof of the claim that includes:

- diagnosis
- date of service
- amount of charge
- name, address and type of provider
- provider tax ID number, if known
- name of enrollee
- enrollee's ID number
- name of patient
- description of each service or purchase
- information on any other group health insurance plan(s) under which you may be covered
- accident information, if applicable
- proof of payment, if applicable

If the proof of payment you receive from a provider contains information in a foreign language, please provide the Plan with a translation of this information, if possible.

The UniCare State Indemnity Plan claim form may be used to submit written proof of a claim. For your convenience, a claim form can be found in Appendix E at the back of this Handbook. You can also print or request this form from www.unicarestateplan.com (click on "Forms and Documents").

Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

Filing Deadline

Written proof of a claim must be submitted to the Plan within two years from the date of service. Claims submitted after two years will be accepted for review if it is shown that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required time frame.

Checking Your Claims for Billing Accuracy

Bill Checker Program

The goal of the Bill Checker Program is to detect overpayments that are the result of billing errors that only you, as the patient, may recognize. Just as you might do with your utility bills, the Plan encourages you to review all of your medical bills for accuracy. In those instances where you do detect a billing error and you are able to obtain a corrected bill from your provider, you will share in any actual savings realized by the Plan.

What You Need to Do

You must request that the provider send you an itemized bill for the services you received. As soon as possible, review this bill for any charges that indicate treatment, services or supplies that you did not receive. Check items such as:

- Did you receive the therapy described on the bill?
- Did you receive x-rays as indicated on your bill?
- Are there duplicate charges on the same bill?
- Have you been charged for more services than you received?
- Did you receive the laboratory services described on the bill?
- Does the room charge reflect the correct number of days?
- Were you charged for the correct type of room?

When Errors Are Detected

If you find an error, contact the provider or the provider's billing office and report the exact charges you are questioning. Request an explanation of any discrepancies and ask for a revised itemized bill showing any adjustments.

How to Receive Your Share of the Savings

To receive your share of the savings, you must send copies of both the original and revised bill(s) to the Plan, along with the completed Bill Checker form. For your convenience, a Bill Checker form can be found in Appendix F at the back of this Handbook.

 You can also request this form from www.unicarestateplan.com. Be sure to include the enrollee's name and identification number on the Bill Checker form. The Plan will review the two bills and, if a billing error is confirmed, you will receive 25% of any savings that the Plan realizes. All reimbursements are subject to applicable state and federal income taxes.

Provider Bills Eligible under the Program

All bills for which UniCare provides the primary benefits are eligible under the Bill Checker Program. Bill Checker is not applicable to members who have Medicare as their primary coverage. This program may not apply to certain inpatient bills paid under the Diagnosis Related Group (DRG) methodology. Bills for prescription drugs and mental health/substance abuse services are excluded.

Claims Review Process

The PLUS Plan routinely reviews submitted claims to evaluate the accuracy of billing information about services performed. The Plan may request written documentation such as operative notes, procedure notes, office notes, pathology reports and x-ray reports from your provider. In cases of suspected claim abuse or fraud, the Plan may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician chosen by the Plan. This examination must be approved by the Executive Director of the GIC and will be performed at no expense to the member.

Restrictions on Legal Action

No legal action or suit to recover benefits for charges incurred while covered under the PLUS Plan may be started before 60 days after written proof of a claim has been furnished. Further, no such action or suit may be brought more than three years after the time such proof has been furnished. If either time limit is less than permitted by state law in the state you lived in when the alleged loss occurred, the limit is extended to be consistent with that state law.

Right of Reimbursement

The Plan will have a lien on any recovery made by you or your dependent for an injury or disease to the extent that you or your dependent has received benefits for such injury or disease from the Plan. That lien applies to any recovery made by you or your dependent from any person or organization that was responsible for causing such injury or disease, or from their insurers. Neither you nor your dependent will be required to reimburse the Plan for more than the amount you or your dependent recover for such injury or disease.

You or your dependent must execute and deliver such documents as may be required, and do whatever is necessary to help the Plan in its attempts to recover benefits it paid on behalf of you or your dependent.

Claims Inquiry

If you have questions about your claims, you can contact the Andover Service Center in one of the following ways to request a review of your claim:

- Call us at (800) 442-9300.
-  E-mail us from www.unicarestateplan.com by clicking on "Contact Us."
- Write to the UniCare State Indemnity Plan/PLUS, Claims Department, P.O. Box 9016, Andover, MA 01810-0916.

If you have additional information, please include it with your letter. You will be notified of the result of the investigation and of the final determination.

24-Hour Access to Claims Information

You can also check the status of your claims 24 hours a day, seven days a week in the following two ways:

1. Call us at (800) 442-9300 and select the option to access our automated information line.
2. Log onto www.unicarestateplan.com. Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. For instance, you may be covered as a dependent under your spouse's plan in addition to coverage under your own plan, or your child may be covered under both plans. When you or your dependents are covered by two or more plans, one plan is identified as the primary plan for coordination of benefits (COB) and determining the order of payment. Any other plan is then the secondary plan.

If the PLUS Plan is the primary plan, benefit payments will be made in accordance with the benefits payable under the Plan without taking the other plan's benefits into consideration. A secondary plan may reduce its benefits if payments were paid by the PLUS Plan. If another plan is primary, benefit payments under the PLUS Plan are determined in the following manner:

(a) The PLUS Plan determines its covered expenses—in other words, what the Plan would pay in the absence of other insurance; then

(b) The PLUS Plan subtracts the primary plan's benefits from the covered expenses determined in (a) above, and then

(c) The PLUS Plan pays the difference, if any, between (a) and (b)

The term "**primary plan's benefit**" includes the benefit that would have been paid had the claim been filed with the other plan. For those plans that provide benefits in the form of services, the reasonable cash value of each service is considered as the charge and as the benefit payment. All COB is determined on a calendar year basis for that part of the year the person had coverage under the Plan.

For the purposes of COB, the term "**plan**" is defined as any plan, including HMOs, that provides medical or dental care coverage including, but not limited to, the following:

- group or blanket coverage
- group practice or other group prepayment coverage, including hospital or medical services coverage
- labor-management trusteed plans
- union welfare plans
- employer organization plans
- employee benefit organization plans
- Coverage under a governmental plan, or coverage required or provided by law. This would include any legally required, no-fault motor vehicle liability insurance. This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.
- automobile no-fault coverage

The term "plan" does not include school-accident type plans, or coverage that you purchased on a non-group basis.

Determining the Order of Coverage

The following are the rules by which the PLUS Plan and most other plans determine order of payment—that is, which plan is the primary plan and which plan is the secondary plan:

(a) The plan without a COB provision is primary.

(b) The plan that covers the person as an employee, member, or retiree (that is, other than a dependent) determines benefits before the plan that covers the person as a dependent.

(c) The order of coverage for a dependent child who is covered under both parents' plans is determined as follows:

1. The primary plan is the plan of the parent whose birthday falls first in the calendar year; or
2. If both parents have the same birthday, the primary plan is the plan that has covered a parent for the longest period of time.

This is called the "**birthday rule**." However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

(d) The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, is determined in the following order:

1. first, the plan of the parent who is decreed by the court as financially responsible for the health care expenses of the child
2. second, if there is no court decree, the plan of the parent with custody of the child
3. third, if the parent with custody of the child is remarried, the plan of the stepparent
4. finally, the plan of the parent who does not have custody of the child

(e) The plan that covers a person as an active employee (that is, someone who is not laid off or retired) determines benefits for that person and his or her dependents before the plan that covers that same person as a retiree.

This is called the "**active before retiree**" rule. However, if the other plan's rule is based on length of coverage, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied when trying to determine the order of coverage, the plan that has covered the person longer determines benefits before the plan that has covered that same person for the shorter period of time.

Right to Receive and Release Information

In order to fulfill the terms of this COB provision or any other provision of similar purpose:

- a claimant must provide the Plan with all necessary information
- the Plan may obtain from or release information to any other person or entity

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the PLUS Plan. If it does, the PLUS Plan may pay that amount to the organization that made the payment. That amount will be treated as if it were a benefit payable under the PLUS Plan. The PLUS Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payments made by the PLUS Plan is more than it should have been under the COB provision, the Plan may recover the excess from one or more of the following:

- the persons it has paid or for whom it has paid
- the insurance companies, or
- other organizations

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Modification of Coordination of Benefits Provisions for Persons Enrolled in Medicare Parts A and/or B

The benefits for an enrollee or his/her dependent covered under the PLUS Plan and enrolled in Medicare will be determined as follows:

(a) Expenses payable under Medicare will be considered for payment only to the extent that they are covered under the PLUS Plan and/or Medicare.

(b) In calculating benefits for expenses incurred, the total amount of those expenses will first be reduced by the amount of the actual Medicare benefits paid for those expenses, if any.

(c) PLUS Plan benefits will then be applied to any remaining balance of those expenses.

Special Provisions Applicable to Senior Employees and Senior Dependents Eligible for Medicare

A senior employee is an active employee age 65 or over who is eligible for medical coverage under the PLUS Plan. A senior dependent is the spouse, age 65 or older, of an active employee who qualifies as a dependent of the employee.

Senior employees and senior dependents may continue medical coverage under the PLUS Plan regardless of their eligibility for, or participation in, Medicare.

Medical Coverage Primary to Medicare Coverage for the Disabled

A disabled employee is an employee covered under the PLUS Plan who is under age 65 and who is entitled to Medicare disability for reasons other than End Stage Renal Disease. A disabled dependent is a dependent who is under age 65 and who is entitled to Medicare disability benefits for reasons other than End Stage Renal Disease.

Disabled employees and disabled dependents may continue their medical coverage under the PLUS Plan, regardless of their eligibility for or participation in Medicare.

Health Coverage Primary to Medicare Coverage for Covered Persons Who Have End Stage Renal Disease

For all covered persons with end stage renal disease (ESRD), coverage under the PLUS Plan will be primary to Medicare during the Medicare ESRD waiting period and the Medicare ESRD coordination period.

"**End Stage Renal Disease**" means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.

"**Medicare ESRD Waiting Period**" is generally the first three months after starting dialysis. You are not entitled to Medicare until after the three-month waiting period. This waiting period can be waived or shortened if a member participates in a self-dialysis training program or is scheduled for an early kidney transplant, respectively.

"**Medicare ESRD Coordination Period**" is 30 months long and occurs **after** the ESRD waiting period. The ESRD coordination period begins on the date that Medicare became effective **or would have become effective on the basis of ESRD**.

During that 30-month period, the PLUS Plan, for the purpose of the COB provision, is the primary payer and Medicare is the secondary payer. After the 30 months, Medicare becomes the primary payer while the Plan becomes the secondary payer. At this point, you must change health plans. Contact the GIC at:

Group Insurance Commission
P.O. Box 8747
Boston, MA 02114-8747

Appeal Rights

You have the right to appeal a benefit determination made by the PLUS Plan within 60 days of the notification of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation (at your own expense) that you or your health care provider believes supports your position.

The Plan will conduct a review of the submitted documentation, and a decision will be made within 30 days after receipt of your written request. The results of the appeal review will be sent to you in writing. The letter will contain the specific reasons for the Plan's decision and, if applicable, instructions as to any additional appeal procedures that may be available.

Appeals relating to the Managed Care Review Program (inpatient hospital admissions, certain outpatient diagnostic and surgical procedures, durable medical equipment, home health care, physical and occupational therapy, and chiropractic and osteopathic manipulation) should be directed to:

UniCare State Indemnity Plan/PLUS
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

All other appeals should be directed to:

UniCare State Indemnity Plan/PLUS
Appeals Review
P.O. Box 2075
Andover, MA 01810-0037

Request and Release of Medical Information

The GIC's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, refer to the GIC's Notice of Privacy Practices in Appendix A at the back of this Handbook.

Overview

The Managed Care Program under the PLUS Plan includes the following components:

1. Managed Care Notification Requirements
2. Utilization Management
3. Medical Case Management
4. Quality Centers and Designated Hospitals for Transplants

The Managed Care Program determines the medical necessity and appropriateness of certain health care services by reviewing clinical information. This process, called Utilization Management, a standard component of most health care plans, ensures that benefits are paid appropriately for services that meet the Plan's definition of medical necessity. Managed Care Program staff will inform you in advance regarding what services will be covered. This Program helps control costs while preserving the ability of the Group Insurance Commission to offer the benefits of an indemnity plan to members.

These criteria are developed with input from actively practicing physicians in the Plan's service area, and are developed in accordance with the standards adopted by the national accreditation organizations. They are updated at least three times a year, or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice. These criteria are evidence-based, whenever possible. Managed Care Program staff will inform you or your provider in advance regarding what services will be covered.

The Managed Care Program staff includes patient advocates who are registered nurses and other nurse reviewers working with physician advisors. To determine medical necessity, nurses speak with your physicians, hospital staff, and/or other health care providers to evaluate your clinical situation and the circumstances of your health care. A physician advisor may speak with your physician on behalf of the Managed Care Program to discuss the proposed treatment and/or the setting in which it will be provided.

Managed Care Notification Requirements

The review process is initiated when you, or someone on your behalf, notifies the Andover Service Center that:

- you or your dependent will be or has been admitted to the hospital; or
- a provider has recommended one of the procedures or services noted on the Notification Requirements chart on the following pages.
- You will also find the Plan's Notification Requirements on the Plan's web site: www.unicarestateplan.com.

When You Use Massachusetts PLUS Providers – When you use a PLUS provider in Massachusetts, the provider is responsible for the managed care notification requirements.

When You Use Any Other Providers – When you use a non-PLUS provider in Massachusetts, or **any** provider outside Massachusetts, you are responsible for meeting the managed care notification requirements. **Important: If you fail to notify the Andover Service Center within the required time frame as specified in the Notification Requirements chart starting on page 20, your benefits may be reduced by as much as $500. The purpose of notifying the Plan is to give the Plan sufficient time to determine if the proposed service will be covered. This process minimizes your risk of incurring charges for services that are not covered by the Plan.**

When you call the Plan to give notification of an admission or service, please have the following information available:

- The hospital admission date or the start of service date
- The name, address and phone number of the admitting or referring physician, as well as the fax number if possible
- The name, address and phone number of the facility or vendor, as well as the fax number if possible

Please refer to the following pages for specific notification requirements and responsibilities.

☎ Managed Care Notification Requirements*

Treatment / Service	Notification Requirement
An Overnight Hospital Stay: ▪ Non-emergency Admission ▪ Emergency Admission ▪ Maternity Admission	 At least 7 calendar days before the admission Within 24 hours (next business day) As soon as you know your expected due date or at least 7 days in advance of your admission **(you must also call again within one business day of being admitted to the hospital)**
Organ Transplants: Liver, Lung, Kidney, Heart, Bone Marrow, Simultaneous Kidney and Pancreas, All Other	At least 21 calendar days before transplant-related services begin
Durable Medical Equipment: (if the purchase price exceeds $500 or the expected rental charges will exceed $500 over the period of use)	At least one business day before ordering the equipment
Home Health Care Provided By: ▪ Home Health Agencies ▪ Visiting Nurse Associations ▪ Home Infusion Therapy Companies ▪ Private Duty Nurses	At least one business day before the services begin
Manipulative Therapy Provided By: ▪ Chiropractors ▪ Medical and Osteopathic Physicians	At least one business day before your first appointment date
Physical Therapy	At least one business day before your first appointment date
Occupational Therapy	At least one business day before your first appointment date

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

*Claims submission does not constitute notification.

☎ Managed Care Notification Requirements* (cont'd)

Treatment / Service	Notification Requirement
Selected Procedure Review: (Some of the procedures listed below may be performed in a doctor's office.)	At least seven (7) calendar days before the procedure for **non-emergency** procedures. If you are not sure whether the procedure is subject to these notification requirements, please call the Andover Service Center at (800) 442-9300.
Procedure	**Definition**
Arthroscopy of the knee for diagnostic purposes only	Examination of the interior of the knee using an endoscope that is inserted into the joint through a small incision
Cholecystectomy	Removal of the gallbladder by any method
CT Scans – Computerized Axial Tomography	
▪ Abdomen and/or Pelvis	Special computerized x-ray of the abdomen or pelvis
▪ Cervical Spine	Special computerized x-ray of the neck
▪ Thoracic Spine	Special computerized x-ray of the middle back
▪ Lumbosacral Spine	Special computerized x-ray of the lower back
▪ Thoracic Cavity	Special computerized x-ray of the chest
Dilation and Curettage (D & C)	Stretching the cervix and removing or destroying the endometrial lining
Discectomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lower back
Hysterectomy	Removal of the uterus (through the abdomen or vagina) by any method
Hysteroscopy and/or Hysteroscopic Endometrial Ablation	Examination through a telescopic tube (hysteroscope) of the inside of the uterus for diagnosis and/or treatment such as removal or destruction of the endometrial lining or lesions such as fibroids or polyps
Laminectomy/Laminotomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

*Claims submission does not constitute notification.

☎ Managed Care Notification Requirements* (cont'd)

Procedure	Definition
MRI – Magnetic Resonance Imaging	
▪ Abdomen and/or Pelvis	Imaging study of the abdomen or pelvis
▪ Knee	Imaging study of the knee
▪ Cervical Spine	Imaging study of the neck
▪ Thoracic Spine	Imaging study of the middle back
▪ Lumbosacral Spine	Imaging study of the lower back
▪ Thoracic Cavity	Imaging study of the chest
Pelvic Laparoscopy	Examination through a telescopic tube (laparoscope) of the inside of the pelvis (the lower abdominal area) for diagnosis and/or treatment, aspiration, removal or destruction of abnormalities of the ovaries, fallopian tubes, uterus, female pelvic organs or surrounding structures
Sinus Surgery	Any procedure by any method that opens, removes or treats the nasal sinuses
Spinal Fusion of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
Spinal Instrumentation of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
UGI Endoscopy	Examination through a flexible telescopic tube (endoscope) of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach, and duodenum) for diagnosis and/or treatment

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

*Claims submission does not constitute notification.

Utilization Management Program

Inpatient Hospitalizations

Initial Review: The PLUS Plan must review and determine the medical necessity of all inpatient hospital admissions. Your PLUS provider will notify the Plan regarding your admission to a Massachusetts PLUS hospital. If you or your dependent is being admitted to a non-PLUS hospital in Massachusetts or to any hospital outside Massachusetts, you or someone on your behalf must initiate this process by calling the Andover Service Center at least seven (7) days in advance of a non-emergency admission, and within 24 hours or the next business day of an emergency admission.

The purpose of this process is to inform you whether the admission will be considered for benefits under the Plan prior to a non-emergency admission, or as soon as possible after an emergency admission. This minimizes your risk of incurring charges for non-covered services.

Upon notification, a patient advocate will contact your physician to discuss the medical necessity and appropriateness of the treatment plan and setting.

You and your physician will each receive a notice in the mail telling you if the Plan has confirmed the medical necessity and appropriateness of the admission. This notice will also specify the initial length of stay approved for the admission.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will attempt to speak with your physician before the Plan makes a final decision. If the Plan determines that the admission is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

Continued Stay Review: Your physician may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether a continued hospital stay is medically necessary and appropriate. You do not have to contact the Plan. The patient advocate will stay in touch with your physician while you are in the hospital and work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the patient advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will speak with your physician before the Plan makes a final decision. If the Plan determines that the continued stay is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

Durable Medical Equipment Over $500

Any Durable Medical Equipment (DME) ordered by a physician that is expected to cost more than $500 is subject to Plan review. The $500 cost may be the result of either the purchase price or the total rental charges. When you or your dependent use a PLUS DME provider for Durable Medical Equipment, the PLUS provider will notify the Plan for you.

The Plan must be notified at least one (1) business day before the equipment is ordered from the equipment provider. Upon notification, a patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the equipment. A patient advocate will notify you regarding whether the Plan will authorize coverage for the equipment.

If you obtain equipment through a PLUS DME provider, the authorized item will be covered at 100% of the allowed amount. Please note that if a covered item is not available through a PLUS DME provider, although it is authorized, it will only be covered at 80% of the allowed amount after the calendar year deductible.

Home Health Care

When a physician prescribes home health care services, the Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate will call your health

care provider to obtain clinical information that will be used to determine the medical appropriateness of the home health care services. A patient advocate will notify you or your provider regarding whether the Plan will authorize coverage for the services.

Manipulative Therapy

Manipulative therapy refers to any hands-on treatment provided by a chiropractor or a medical or osteopathic physician. The Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the manipulative therapy services.

Physical Therapy

When a physician prescribes physical therapy services for you or for your dependent, the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the physical therapy services.

Physical therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Occupational Therapy

When a physician prescribes occupational therapy services for you or for your dependent, the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the occupational therapy services.

Occupational therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. parent education
2. assistance and training in breast or bottle feeding, and
3. performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan as soon as you know your expected due date or at least seven (7) days in advance of your admission. You must notify the Plan again within one (1) business day of being admitted to the hospital. Please call a patient advocate if you have any questions.

Selected Procedures

Members scheduled on a non-emergency basis for one of the selected procedures listed on pages 21–22 must notify the Plan at least seven (7) calendar days before the scheduled date of the procedure. The Plan requires notification, whether the procedure is being done in a hospital on an inpatient or outpatient basis, in a freestanding facility or in a physician's office. If you have scheduled such a procedure with a Massachusetts PLUS physician, the physician will notify the Plan for you.

If you are scheduled to have a procedure or special test done and you do not know the medical term for it, ask your physician to call the Andover Service Center at (800) 442-9300 to find out if prior notification is needed. Upon notification, a patient advocate will contact your physician to obtain clinical information that will be used to determine the medical necessity of the planned procedure and the appropriateness of the setting in which it will be provided.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the planned procedure, a physician advisor will talk to your physician before a final decision is made. This decision will be communicated to you and your physician.

Expedited Appeals Process

If an initial denial occurs before or while health care services are being provided, and the attending physician or patient believes that the determination warrants an immediate reconsideration, either party may request reconsideration of that determination over the telephone on an expedited basis.

For an immediate reconsideration, the Andover Service Center must receive the request and all supporting information within three (3) business days of the initial notification of denial. The reconsideration will be completed within two (2) business days of receipt of all necessary supporting documentation. The decision is then communicated in writing to the patient and the patient's health care provider.

If the denial is upheld, the patient can take the next step and appeal the decision to:

UniCare State Indemnity Plan/PLUS
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Medical Case Management Program

The Medical Case Management Program facilitates the timely provision of appropriate, cost-effective, quality health care services that are tailored to meet an individual's health care needs. A medical case manager is a registered nurse with the expertise to assist you and your family when you are faced with a serious medical problem such as stroke, cancer, spinal cord injury or other conditions that require multiple medical services. The medical case manager will:

- help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning, and enhance the coordination of services among multiple providers
- work with the attending physician and other involved health care providers to evaluate the present and future health care needs of the patient
- provide valuable information regarding available resources for the patient
- work with the mental health/substance abuse benefits administrator when you or your dependent's condition requires both medical and mental health services, to coordinate services and maximize your benefits under the Plan
- explore alternative funding sources or other resources in cases where medical necessity exists but there is a limit to coverage under the Plan
- facilitate the management of chronic disease states by promoting education, wellness programs, self-help and prevention
- promote the development of an appropriate plan of care to ease the transition from a stay in a facility to the return home

Coronary Artery Disease Secondary Prevention Program

The Coronary Artery Disease Secondary Prevention Program is designed to help you make the necessary lifestyle changes that can reduce your cardiac risk factors. It is available to members with a history of heart disease. The program is available through the Medical Case Management Program. You may call a medical case manager to ask about your eligibility and available programs.

Quality Centers and Designated Hospitals for Transplants

The PLUS Plan has designated certain hospitals as Quality Centers for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high quality care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible Plan members at specialized facilities. A medical case manager is available to support the patient and family before the transplant procedure and throughout the recovery period. The medical case manager will:

- assess the patient's ongoing needs
- coordinate services while the patient is awaiting a transplant
- help the patient and family to optimize Plan benefits
- maintain communication with the transplant team
- facilitate transportation and housing arrangements, if needed
- facilitate discharge planning alternatives
- coordinate home care plans as necessary
- explore alternative funding sources or other resources in cases where there is need but there are limited benefits under the Plan

Although members have the freedom to choose any health care provider for these procedures, you can maximize your benefits when you use one of these Quality Centers. You or someone on your behalf should notify the Plan as soon as your physician recommends a transplant evaluation.

A Summary of Your Medical Benefits

This section contains a summary of your medical benefits under the PLUS Plan, as follows:

- the level of benefits coverage – either with a PLUS or a non-PLUS provider
- any coinsurance, copays, or deductibles you are responsible for paying in connection with a service or supply (for copay and deductible amounts, please refer to the Your Costs section)
- any limits on the maximum number of visits allowed per calendar year
- any maximum dollar amounts per calendar year that are associated with a service or supply

Important: The information contained in this section is only a summary of your medical benefits. For additional details of your medical plan benefits coverage, please refer to the Description of Covered Services section of this Handbook, which follows the Benefit Highlights section.

Look for the **book symbol** 🕮 next to each service listed in the Benefit Highlights section for the corresponding page in the Description of Covered Services section or other sections where this benefit is more fully described.

The **telephone symbol** ☎ you see throughout this Handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Andover Service Center at (800) 442-9300. Failure to do so will result in a reduction in benefits of up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states). Please refer to the Managed Care Program section of this Handbook (the preceding section) for more information regarding the notification requirements associated with these benefits.

The **computer symbol** 💻 that you see throughout this Handbook indicates that information on the highlighted topic is available on the Plan's web site, www.unicarestateplan.com.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ **Inpatient Hospital Services** in an Acute Medical, Surgical or Rehabilitation Facility		📖 Also see page 37
Semi-Private Room, ICU, CCU and Ancillary Services	100% after the inpatient hospital quarterly deductible	80% after the inpatient hospital quarterly deductible
Medically Necessary Private Room	100% for the first 90 days in a calendar year after the inpatient hospital quarterly deductible; then 100% at the semi-private level	80% for the first 90 days in a calendar year after the inpatient hospital quarterly deductible; then 80% at the semi-private level. The 20% coinsurance amount does not count toward the out-of-pocket maximum
Inpatient Diagnostic Laboratory and Radiology Expenses	100%	80%
☎ **Select Complex Procedures / High-Risk Maternity Care** (See Appendix D for list of procedures and hospitals.)		📖 Also see page 52
Select Complex Procedures and High-Risk Maternity Care	100% after the inpatient hospital quarterly deductible at a Designated Hospital	80% after the inpatient hospital quarterly deductible
☎ **Transplant Services**		📖 Also see page 43–44
Quality Centers and Designated Hospitals for Transplants	100% after the inpatient hospital quarterly deductible	100% after the inpatient hospital quarterly deductible
Other Hospitals	80% after the inpatient hospital quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the inpatient hospital quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Other Inpatient Facilities		Also see page 37
▪ Sub-acute Care Hospital/ Facility ▪ Transitional Care Hospital/ Facility ▪ Long-term Care Hospital/ Facility ▪ Chronic Disease Hospital/ Facility ▪ Skilled Nursing Facility	80% up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible up to a calendar year maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Emergency Treatment for an Accident / Sudden Serious Illness		Also see page 37–38
Emergency Room Charge	100% after the emergency room copay; copay waived if admitted	100% after the emergency room copay; copay waived if admitted
Radiology	100%	100%
Diagnostic Laboratory	100%	100%

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Non-Emergency Treatment		Also see page 37–38
Emergency Room Charge	100% after the emergency room copay	100% after the emergency room copay and after the calendar year deductible
Radiology	100%	80%
Diagnostic Laboratory	100%[1]	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Surgery		Also see page 38
Inpatient	100%	80%
Outpatient Surgery at a Hospital	100% after the outpatient surgery quarterly deductible	80% after the outpatient surgery quarterly deductible
Surgery at an Ambulatory Surgical Facility or Physician's Office	100%	80%

1 Please visit our web site at www.unicarestateplan.com for the names of PLUS providers, or call the Andover Service Center at (800) 442-9300.

To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Outpatient Medical Care		Also see pages 38–43
For Services at a Hospital (other than the services listed below)	100%	80% after the calendar year deductible
Diagnostic Laboratory Testing	100%	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Radiology	100%	80%
☎ Physical Therapy and ☎ Occupational Therapy	100% after the copay	100% after the copay and after the calendar year deductible
Speech Therapy	100% up to a maximum benefit of $2,000 per calendar year	80% after the calendar year deductible up to a maximum benefit of $2,000 per calendar year
Chemotherapy	100%	80% after the calendar year deductible

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For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Physician Services		Also see page 42
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after the applicable office visit copay per visit.	80% after the applicable office visit copay per visit and after the calendar year deductible.
Hospital Inpatient	100%	80%
Emergency Treatment	100%	100%
Chiropractic Care or Treatment	80% after the chiropractic visit copay; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the chiropractic visit copay and after the calendar year deductible; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the calendar year deductible or the out-of-pocket maximum.
Private Duty Nursing		Also see page 43
Provided in Home Setting Only	80% for a registered nurse up to a calendar year maximum benefit of $8,000. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% for a registered nurse up to a calendar year maximum benefit of $8,000 after the calendar year deductible. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Home Health Care		Also see page 40–41
Medicare Certified Home Health Agencies and Visiting Nurse Associations[1]	80%	80% after the calendar year deductible

1 A program is available to enhance the benefit for Home Health Care by using designated providers. Check the list of PLUS providers at www.unicarestateplan.com, or call the Andover Service Center at (800) 442-9300 for more information.

To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ Home Infusion Therapy		Also see page 54
	100%	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Preventive Care		Also see pages 42–43
Office Visits (refer to frequency limits on pages 42–43)	100% after the applicable copay per visit	80% after the applicable copay per visit.
Annual Gynecological Visits	100% after the applicable copay per visit	80% after the applicable copay per visit.
Immunizations	100%	100%
Covered Laboratory Testing[1]	100%[1]	80%[1]. The 20% coinsurance does not count toward the out-of-pocket maximum.
Hospice		Also see pages 44
Medicare Certified Hospice	100%	80% after the calendar year deductible
Bereavement Counseling	80% up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $1,500 per family after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

1 For information on covered preventive laboratory services, see the preventive care schedule on pages 42–43.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Early Intervention Services for Children		Also see page 40
Programs Approved by the Department of Public Health	80% up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance does not count toward the out-of-pocket maximum.
Ambulance		Also see page 38
	100%	100% of the first $25; then 80% after the calendar year deductible
Coronary Artery Disease (CAD) Secondary Prevention Program		Also see page 26
Designated Programs Available Through Medical Case Management	90%. The 10% coinsurance does not count toward the out-of-pocket maximum.	Not covered
Durable Medical Equipment (DME)		Also see pages 45
	100%[1]	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

1 If an item is not available through a PLUS Provider and you obtain it from another provider, it will be covered at 80%.
To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Hospital-Based Personal Emergency Response Systems (PERS)		Also see page 45
Installation	80% up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $50 after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Rental Fee	80% up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $40 per month after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Prostheses[1]		Also see page 43
	80%	80% after the calendar year deductible
Braces[2]		Also see page 39
	80%	80% after the calendar year deductible
Hearing Aids		Also see page 40
	100% of the first $500; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum.	100% of the first $500 after the calendar year deductible; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum.

1 Breast prostheses are covered at 100% when you use a PLUS provider, or at 100% after the calendar year deductible when you use a non-PLUS provider.

2 Orthopedic shoe(s) with attached brace is covered at 100% when you use a PLUS provider, or at 100% after the calendar year deductible when you use a non-PLUS provider.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Eyeglasses / Contact Lenses		Also see page 51
	80%. Limited to the initial set within six months following cataract surgery	80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery
Routine Eye Examinations (including refraction)		Also see page 49 & 51
	100% after the applicable copay. Covered once every 24 months.	80% after the applicable copay. Covered once every 24 months.
Family Planning Services		Also see page 40
Office Visits and Procedures	100% after the applicable copay per visit	100% after the applicable copay per visit and after the calendar year deductible
All Other Covered Medical Services		Also see pages 38–46
	80%	80% after the calendar year deductible

Prescription Drug Plan – Benefits Administered by Express Scripts

See page 67.
For more information, call (877) 828-9744.

Mental Health, Substance Abuse and Employee Assistance Programs – Benefits Administered by United Behavioral Health.

See page 77.
For more information, call (888) 610-9039.

For your deductible and copay amounts, see the charts in the Your Costs section.
All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

The following pages contain descriptions of various covered services under the PLUS Plan. Please refer to the Benefit Highlights section for information regarding benefit percentages and maximums, copays, coinsurance amounts, deductibles, out-of-pocket maximum amounts and durations of benefits that apply to these covered services. The Benefit Highlights section also shows you the difference in the level of coverage when you use PLUS providers versus non-PLUS providers. For information on the Plan's medical review requirements and to find out when prior authorization is needed, please refer to the Managed Care Program section.

☎ Inpatient Hospital Services

Charges for the following services qualify as covered hospital charges if the services are for a hospital stay.

1. Room and board provided to the patient
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you or your covered dependent is scheduled to enter the same hospital where the tests are performed within seven (7) days after they are performed. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital, except for special nursing or physician services
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

Services at Other Inpatient Facilities

Other inpatient facilities include:

- Sub-acute Care Hospitals/Facilities
- Transitional Care Hospitals/Facilities
- Long-term Care Hospitals/Facilities
- Chronic Disease Hospitals/Facilities
- Skilled Nursing Facilities

Covered charges for these facilities include the following services:

1. Room and board
2. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Such drugs, biologicals, medical supplies, appliances, and equipment as are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished to patients of the facility by a hospital or any other health care provider
7. Other medically necessary services as are generally provided by such treatment facilities

Coverage in "Other Inpatient Facilities"
NOTE: To qualify for coverage in "Other Inpatient Facilities," the purpose of the care in these facilities must be the reasonable improvement in the patient's condition. A physician must certify that the patient needs and receives, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis. Continuing care for a patient who has not demonstrated reasonable clinical improvement is not covered.

Emergency Treatment for an Accident or Sudden/Serious Illness

An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of

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health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

Massachusetts provides a 911 emergency response system throughout the state. The Plan will cover medical and transportation expenses incurred as a result of the emergency medical condition in accordance with the terms of the Plan. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

☎ Surgical Services

The payment to a surgical provider for operative services includes the usual pre-operative, intra-operative and post-operative care.

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or surgical center)
2. Services of an assistant surgeon when:
   (a) medically necessary
   (b) the assistant surgeon is trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   (c) the assistant surgeon serves as the first assistant surgeon. (Second or third assistants are not covered.)
3. Reconstructive breast surgery:
   (a) All stages of breast reconstruction following a mastectomy
   (b) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
   (c) Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

   Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts. Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is more generous than the federal law, your benefits will be paid in accordance with your state's law.
4. All other reconstructive and restorative surgery, but limited to the following:
   (a) Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five (5) years of the removal surgery.
   (b) Correction of a congenital birth defect that causes functional impairment for a minor dependent child.

Medical Services

Charges for the following services qualify as covered medical charges, but only if they do not qualify as covered hospital or surgical charges:

1. **Ambulance/Air Ambulance** – only in the event of an emergency and when medically necessary. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation to or from medical appointments, including dialysis, is not a covered service.
2. **Anesthesia** and its administration
3. **Audiology Services** – expenses for the diagnosis of speech, hearing and language disorders are covered when provided by a licensed audiologist when the services are provided in a hospital,

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clinic or private office. Services provided in a school-based setting are not covered. The Plan does not cover services that a school system is obligated to provide under Chapter 766 in Massachusetts or under similar laws in other states.

4. **Braces** – replacement of such equipment is also covered when required due to pathological change or normal growth.

   Also see Orthotics.

5. **Cardiac Rehabilitation Treatment** – provided by a cardiac rehabilitation program (see definition on page 52).

6. **Certified Nurse Midwife Services** – provided in the home or in a hospital.

7. **Circumcision** – when provided for newborns up to 30 days from birth.

8. **Crutches** – replacement of such equipment is covered when required due to pathological change or normal growth.

9. **Diabetes** – benefits will be paid for charges incurred by a covered person for medically necessary equipment, supplies and medications for the treatment of diabetes. Coverage will include outpatient self-management training and patient management, as well as nutritional therapy.

   Coverage will apply to services and supplies prescribed by a doctor for insulin dependent, insulin using, gestational and non-insulin using diabetes. The PLUS Plan will provide benefits for these services and supplies when prescribed by a physician under the medical component of the Plan or under the prescription drug plan as indicated below.

Diabetic drugs, insulin and the following diabetic supplies are covered under the prescription drug component of the Plan:

(a) blood glucose monitors
(b) test strips for glucose monitors
(c) insulin
(d) syringes and all injection aids
(e) lancets and lancet devices
(f) prescribed oral agents
(g) glucose agents and glucagon kits
(h) urine test strips

The following diabetic supplies are covered under the medical component of the Plan:

(a) blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons

(b) test strips for glucose monitors

(c) laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles

(d) insulin pumps and all related supplies

(e) insulin infusion devices

(f) syringes and all injection aids

(g) lancets and lancet devices

(h) urine test strips

(i) insulin measurement and administration aids for the visually impaired

(j) podiatric appliances for the prevention of complications associated with diabetes

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

Diabetes Self-Management Training
Diabetes self-management training and patient management, including medical nutritional therapy, may be conducted individually or in a group, but must be provided by:

- an education program recognized by the American Diabetes Association, or
- a health care professional who is a diabetes educator certified by the National Certification Board for Diabetes Educators

Coverage will include all educational materials for such program. Benefits will be provided as follows:

(a) upon the initial diagnosis of diabetes

(b) when a significant change occurs in symptoms or conditions, requiring changes in self-management

(c) when refresher patient management is necessary, or

(d) when new medications or treatments are prescribed

As used in this provision, "patient management" means educational and training services furnished to a covered person with diabetes in an outpatient setting by a person or entity with experience in the treatment of diabetes. This will be in consultation with the physician who is managing the patient's condition. The physician must certify that the services are part of a comprehensive plan of care related to the patient's condition. In addition, the services must be needed to ensure therapy or compliance or to provide the patient with the necessary skills and knowledge involved in the successful management of the patient's condition.

10. **Early Intervention Services for Children** – coverage of medically necessary Early Intervention Services for children from birth until their third birthdays includes occupational therapy, physical therapy, speech therapy, nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an Early Intervention Services program approved by the Department of Public Health. See the Benefit Highlights section for benefit maximums.
11. **Family Planning Services** – office visits and procedures for the purpose of contraception. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA approved contraceptive drugs and devices are available through the prescription drug plan.
12. **Gynecological Visits** – annual gynecological examination, including Pap smear.
13. **Hearing Aids** – when prescribed by a physician. See the Benefit Highlights section for benefit maximum.
14. **Hearing Screenings** for newborns.
15. ☎ **Home Health Care** – and skilled nursing services provided under a plan of care prescribed by a physician and delivered by a Medicare-certified Home Health Care agency. (Refer to definition of Home Health Care in Plan Definitions on page 54.)

    The following services are only covered if the covered individual is receiving approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

    (a) Part-time, intermittent home health aide services consisting of personal care of the patient and assistance with activities of daily living

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

(b) Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist

(c) Nutritional consultation by a registered dietitian

(d) Medical social services provided by a licensed medical social worker

(e) Durable medical equipment (DME) and supplies provided as a medically necessary component of a physician-approved home health services plan.

However, the following charges do not qualify as covered home health care charges:

(a) Charges for custodial care or homemaking services

(b) Services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.

16. **Infertility Treatment** – non-experimental infertility procedures including, but not limited to:

(a) Artificial Insemination (AI) also known as Inter-uterine Insemination (IUI)

(b) In Vitro Fertilization and Embryo Placement (IVF-EP)

(c) Gamete Intrafallopian Transfer (GIFT)

(d) Zygote Intrafallopian Transfer (ZIFT)

(e) Natural Ovulation Intravaginal Fertilization (NORIF)

(f) Cryopreservation of eggs as a component of covered infertility treatment (costs associated with banking and/or storing inseminated eggs are reimbursable only upon the use of such eggs for covered fertility treatment)

(g) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any

(h) Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer, if any

(i) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility

In Vitro Fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of "Attempt" in the Plan Definitions section).

Charges for the following services are not considered covered services:

(a) Experimental infertility procedures
(b) Surrogacy
(c) Reversal of voluntary sterilization
(d) Procedures for infertility not meeting the Plan's definition on page 55.

Facility fees will be considered as covered services by the Plan only from a licensed hospital or a licensed freestanding ambulatory surgical center.

17. **Laboratory Tests** – must be ordered by a physician.

18. ☎ **Manipulative Therapy** – chiropractic or osteopathic manipulation used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gains exists.

19. ☎ **Occupational Therapy** – by a registered occupational therapist when ordered by a physician

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

20. **Orthotics** – covered when they meet the following criteria:

    (a) ordered by a physician
    (b) custom fabricated (molded and fitted) to the patient's body
    (c) for use by that patient only

21. ☎ **Oxygen** and its administration.

22. ☎ **Physical Therapy** – physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists. The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) and when ordered by a physician.

23. **Physician Services** – medically necessary services provided by a licensed physician acting within the scope of that license providing such services in the home, hospital, physician's office, or other medical facility. Charges by physicians for their availability in case their services may be needed are not covered services. The Plan only pays physicians for the actual delivery of medically necessary services. Any charges for telephone and e-mail consultations are not covered.

24. **Preventive Care Schedule:**

    (a) **For children (up to age 19)** – The Plan covers preventive level office visits or physical examinations for children as follows:

    — two examinations, including hearing screening, while the newborn is in the hospital;
    — every two months until 18 months of age; then
    — every three months from 18 months of age until 3 years of age; then
    — every 12 months from 3 years of age until 19 years of age.

    (b) **For adults (age 19 and over)** – The Plan covers preventive or routine level office visits or physical examinations every 12 months.

    (c) The following screening procedures and laboratory tests performed as a component of preventive care:

    — hemoglobin
    — urinalysis
    — glaucoma testing
    — flexible sigmoidoscopy (exam of the lower bowel)
    — chemistry profile for the purpose of preventive screening includes the following:
      • complete blood count (CBC)
      • glucose
      • blood urea nitrogen (BUN)
      • creatinine
      • transferase alanine amino (SGPT)
      • transferase asparate amino (SGOT)
      • thyroid stimulating hormone (TSH)

    (d) The following screening procedures and laboratory tests performed as indicated:

    — blood cholesterol level (every five years), including high density cholesterol (HDL) and low density cholesterol (LDL), in addition to total cholesterol

    — bone mineral density (BMD) testing of the hip or spine for screening purposes every two years for women over age 40. Peripheral BMD testing of the wrist, forearm, finger and/or heel is not covered as a preventive care benefit.

    — colonoscopy for routine screening (once every 10 years after age 50); however, virtual colonoscopy or virtual colonography is not covered (see Exclusions)

    — mammograms (once between the ages of 35 and 40; yearly after age 40)

    — stool for occult blood (annually after age 50)

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

(e) Gynecological examination annually (every 12 months) for women, including Pap smear

(f) Immunizations

25. ☎ **Private Duty Nursing Care** – highly skilled nursing care needed continuously during a block of time (greater than two hours) provided by a registered nurse while you are confined to your home. Charges for a Licensed Practical Nurse (LPN) are provided as shown in the Benefit Highlights section. Private Duty Nursing Care must:

(a) be medically necessary
(b) provide skilled nursing services, and
(c) be exclusive of all other home health care services
(d) not duplicate services that a hospital or facility is licensed to provide

26. **Prostheses** – replacement of such equipment is also covered when required due to pathological change or normal growth.

27. **Radioactive Isotope Therapy**

28. **Radiotherapy**

29. **Routine Eye Examinations (including refraction)** – covered once every 24 months

30. **Routine Foot Care** – charges for medically necessary routine foot care are covered if accompanied by medical evidence documenting:

- in the case of an ambulatory patient, an underlying condition causing vascular compromise, such as diabetes, or
- in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

31. **Speech-Language Pathology Services** – Expenses for the diagnosis and treatment of speech, hearing and language disorders are covered when provided by a licensed speech-language pathologist or audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered.

Covered speech-language pathology services include the following:

- the examination and remedial services for speech defects caused by physical disorders
- physiotherapy in speech rehabilitation following laryngectomy

The Plan does not cover the following:

- services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states
- language therapy for learning disabilities such as dyslexia
- cognitive therapy or rehabilitation
- voice therapy

32. **Wigs** – are covered for the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to $350 per calendar year.

33. **X-Rays** and other radiological exams.

☎ Transplant Services

Benefits are payable, subject to deductibles, coinsurance, copays and limitations, for necessary medical and surgical expenses incurred for the transplanting of a human organ. (To receive the maximum benefit, please refer to Quality Centers and Designated Hospitals for Transplants on pages 20 and 26.)

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

Human Organ Donor Services

Benefits are payable, subject to deductibles, coinsurance and limitations, for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of a human organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, regardless of whether the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

Hospice Care Services

Upon certification by a physician that the covered individual is terminally ill, benefits are payable for charges incurred for the covered hospice care services when the patient is enrolled in a Medicare-certified hospice program. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice.

A person is considered to be terminally ill when given a medical prognosis of six (6) months or less to live.

List of Covered Hospice Care Services

The Plan covers the following hospice care services:

1. Part-time, intermittent nursing care provided by or supervised by a registered nurse
2. Physical, respiratory, occupational and speech therapy by an appropriate licensed or certified therapist
3. Medical social services
4. Part-time, intermittent services of a home health aide under the direction of a registered nurse
5. Necessary medical supplies and medical appliances
6. Drugs and medications prescribed by a physician and charged by the hospice
7. Laboratory services
8. Physicians' services
9. Transportation needed to safely transport the terminally ill person to the place where that person is to receive a covered hospice care service
10. Psychological, social and spiritual counseling for the patient furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

11. Dietary counseling furnished by a registered dietitian
12. Respite care
13. Bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within 12 months after the date of death and it must be furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

    No hospice benefits are payable for services not included in the List of Covered Hospice Care Services, nor for any service furnished by a volunteer or for which no charge is customarily made.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

Hospital-Based Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a PERS if:

1. the service is provided by a hospital
2. the patient is homebound and at risk medically, and
3. the patient is alone at least four (4) hours a day, five (5) days a week, and is functionally impaired

No benefits are payable for the purchase of a PERS unit.

☎ Durable Medical Equipment (DME)

To meet the Plan's definition of DME, the service or supply must be:

1. provided by a DME supplier
2. designed primarily for therapeutic purposes or to improve physical function
3. provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. able to withstand repeated use, and
5. ordered by a physician

Benefits are payable if the DME service or supply meets the Plan's definition of DME and is determined to be medically necessary, except as described in the Exclusions section of this Handbook.

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use. If you choose to continue to rent the equipment, the Plan will not cover rental charges that exceed the purchase price.

Excluded Items

No benefits are available for personal comfort items such as, but not limited to, air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, whirlpools or spas. These items do not qualify as covered durable medical equipment.

Important: Using PLUS providers will maximize your benefit by reducing your out-of-pocket cost. Visit our web site at www.unicaresateplan.com for a list of PLUS providers for durable medical equipment, or call the Andover Service Center at (800) 442-9300.

Coverage for Clinical Trials

Patient care services provided as part of a qualified clinical trial are covered to the same extent as they would be covered if the patient did not receive care in a qualified clinical trial. Coverage is subject to all other provisions of the Plan including, but not limited to, provisions relating to the use of participating providers and utilization review.

"Patient care service" means a health care item or service provided to an individual enrolled in a qualified clinical trial that is consistent with the patient's diagnosis, consistent with the study protocol for the clinical trial and would be covered if the patient were not a participant in a clinical trial. "Patient care service" does not include:

1. An investigational drug or device. However, a drug or device that has been approved for use in the qualified clinical trial will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device, regardless of whether the Food and Drug Administration has approved the drug or device for use in treating the patient's particular condition.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial
3. Costs associated with managing the research of the clinical trial
4. Costs that would not be covered for non-investigational treatments
5. Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration
8. Services or costs that are not covered under the Plan

The PLUS Plan does not provide benefits for the following services. Please note that charges that are excluded by the Plan do not count toward out-of-pocket maximums and deductible amounts.

1. A service or supply furnished without the recommendation and approval of a physician (that is, without an order).
2. A service or supply reviewed under the Managed Care Program and determined by the Plan not to be medically necessary.
3. A service or supply that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it, or that this treatment has been tried after others have failed, does not make it medically necessary.
4. A service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy, unless:

   (a) furnished by a hospital for routine care of a child during a hospital stay that begins with birth and while the child's mother is confined in the same hospital; or

   (b) furnished by a hospital or physician for covered preventive care, as described under Description of Covered Services on pages 42–43; or

   (c) such service or supply qualifies as a covered Hospice Care service (see page 44)
5. A service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law.
6. A service or supply provided by you, a member of your family or by any person who resides in your home. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.
7. A medical supply or service (such as a court-ordered testing or an insurance physical) required by a third party that is not otherwise medically necessary. Examples of a third party are an employer, an insurance company, a school or a court.
8. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.
9. Acupuncture and acupuncture-related services
10. Anesthesia and other services required for the performance of a service that is not covered under the Plan. Non-covered services include those for which there is no Plan benefit and those that the Plan has determined to be not medically necessary.
11. Arch supports
12. The amount by which a charge for blood is reduced by blood donations
13. Blood pressure cuff (sphygmomanometer)
14. Breast pumps
15. Transportation in chair cars/vans
16. Cognitive rehabilitation or therapy
17. Computer-assisted communication devices
18. Custodial care
19. Dentures or dental prostheses

20. Services related to surgery undertaken as the result of denture wear or to prepare for the fitting of new dentures
21. Dietary or nutritional counseling or services provided by a dietitian or nutritional counselor except for services performed by a registered dietician for members with diabetes (see page 40 for details)
22. Drugs not used in accordance with indications approved by the Food and Drug Administration (off label use of a prescription drug), unless the use meets the definition of medically necessary as determined by the Plan or the drug is specifically designated as covered by the Plan
23. Over-the-counter drugs
24. Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:
    (a) a program established for its civilian employees
    (b) Medicare (Title XVIII of the Social Security Act)
    (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    (d) a program of hospice care
25. Hearing aid batteries or ear molds
26. Hippotherapy
27. Incontinence supplies
28. Experimental treatment for infertility
29. Internet providers or e-mail consultations
30. Language therapy for learning disabilities such as dyslexia
31. Lift or riser chairs
32. Long-term maintenance care or long-term therapy
33. Certain manipulative or physical therapy services, including but not limited to: paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; craniosacral therapy; kinetic therapy; or therapies performed in a group setting
34. Massage therapy or services provided by a massage therapist or neuromuscular therapist
35. A medical service or supply for which a charge would not have been made in the absence of medical insurance
36. Any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate
37. Benefits for the diagnosis, treatment or management of mental health/substance abuse conditions by medical (non-mental health) providers. These benefits are covered when provided by mental health providers (see United Behavioral Health section for coverage details.)
38. Molding helmets and adjustable bands intended to mold the shape of the cranium
39. Orthodontic treatment, including treatment done in preparation for surgery
40. Orthopedic/corrective shoe(s), except when the shoe(s) attaches directly to a brace
41. Orthopedic mattresses
42. Oxygen equipment required for use on an airplane or other means of travel
43. Personal comfort items that could be purchased without a prescription, such as air conditioners, air purifiers, bed pans, blood pressure monitors, commodes, dehumidifiers, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, telephones, televisions, whirlpools or spas and other similar items

44. Private duty nursing services in an acute care hospital or any other inpatient facility
45. Redundant or duplicate services. A service or supply is considered redundant when the same service or supply is being provided or being used, concurrently, to treat the condition for which it is ordered.
46. Reversal of voluntary sterilization
47. Sensory integration therapy
48. Any services and treatments required under law to be provided by the school system for a child
49. Sexual reassignment surgery and related services
50. Smoking cessation programs or medications
51. Stairway lifts and stair ramps
52. Storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with use in a scheduled procedure that is covered under the Plan
53. Surface electromyography (SEMG)
54. Telephone consultations
55. Any type of thermal therapy device
56. Virtual colonoscopy or virtual colonography (standard colonoscopy, however, is covered)
57. Vision care, including:
    (a) orthoptics or visual therapy for correction of vision
    (b) radial keratotomy and related laser surgeries
    (c) other surgeries, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia (except as shown under Routine Eye Examinations in the Benefit Highlights and Covered Services sections)
58. Voice therapy
59. Worksite evaluations performed by a physical therapist to evaluate a patient's ability to return to work

The PLUS Plan limits benefits for the following services and products:

1. **Ambulance** used for transportation services other than in the case of an emergency. Please see the definition of "Emergency Treatment" on page 54. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation required for medical appointments, including dialysis treatment, is not covered.
2. **Air and sea ambulance services** are limited to the medically necessary transfer to the nearest facility equipped to treat the condition.
3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.

   Non-physician assistants at surgery, such as physicians assistants (PAs), nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.
4. **Bone density testing** is not covered when done solely for the purpose of screening or prevention, except as described in Item 24 (d) (Preventive Care Schedule) in the Description of Covered Services section. Peripheral bone mineral density testing of the wrist, forearm, finger and/or heel is not covered as a preventive care benefit.
5. **Cosmetic procedures/services** are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
6. **Dental benefits** are limited. The PLUS Plan is a medical plan, not a dental plan. The PLUS Plan provides benefits for covered services relating to dental care or surgery in the following situations only:

   (a) Emergency treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. This treatment is limited to the initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

   (b) Oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are provided to the same extent as other covered surgical procedures described on page 58.

   (c) The following procedures when a member has a serious medical condition* that makes it essential that he or she be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely:

   (1) extraction of seven (7) or more teeth
   (2) gingivectomies (including osseous surgery) of two (2) or more gum quadrants
   (3) excision of radicular cysts involving the roots of three (3) or more teeth
   (4) removal of one (1) or more impacted teeth

   Facility, anesthesia and related charges are only covered when the dental treatment or services are covered under the Plan.

   Dentures or dental prostheses, and the surgery in preparation for dentures, are not covered under the Plan.

   * *Serious medical conditions include, but are not limited to, hemophilia and heart disease.*

7. **Electrocardiograms** (EKGs) are not covered when done solely for the purpose of screening or prevention.
8. **Eyeglasses/contact lenses** are limited to the provision, replacement or fitting for the initial set only when subsequent to an injury to the eye or up to six (6) months following cataract surgery.
9. **In Vitro Fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of "Attempt" on page 52).
10. **Orthotics** are limited to medically necessary devices. Charges for test or temporary orthotics are not covered. Charges for video tape gait analysis and diagnostic scanning are not covered. Arch supports are also not covered.
11. **Prostate-Specific Antigen (PSA) Test** is covered only if ordered by a physician in conjunction with the treatment of a medical condition.
12. **Respite Care** is limited to a total of five days for a hospice patient in order to relieve the family or the primary care person from caregiving functions. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
13. **Routine screening** is not covered other than the Preventive Care Services specified in the Description of Covered Charges on pages 42–43.
14. **Treatment of Temporomandibular Joint (TMJ) disorder** is limited to the initial diagnostic examination, initial testing and medically necessary surgery.
15. **Weight loss programs** are limited to the treatment of members whose body mass index (BMI) is 40 or more (morbidly obese) while under the care of a physician. Any such program is subject to periodic review for medical necessity and progress.
16. **Wigs** are limited to the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to $350 per calendar year.

Some terms used in the UniCare State Indemnity Plan/PLUS Handbook are defined below as they relate to your benefits. Read these definitions carefully; they will help you understand what is covered under the Plan.

"Acute Care" – a level of care required as a result of the sudden onset or worsening of a condition that necessitates short term, intensive medical treatment. Acute inpatient care must be provided at a facility licensed as an acute care hospital. See definition for "Hospital."

"Advanced Radiology Procedures" – Applies to tests that are commonly referred to as "advanced" or "high-tech" imaging. These tests vary from plain film x-rays by offering providers a more comprehensive view of the human body. Many of these tests also subject members to significantly higher levels of radiation compared to plain film x-rays and are also much more expensive. These procedures include but are not limited to MRIs, CT scans and PET scans.

"Ancillary Services" – the services and supplies that a facility ordinarily renders to its patients for diagnosis or treatment during the time the patient is in the facility. Ancillary Services include such things as:

1. use of special rooms, such as operating or treatment rooms
2. tests and exams
3. use of special equipment in the facility
4. drugs, medications, solutions, biological preparations and medical and surgical supplies used while an inpatient in the facility
5. administration of infusions and transfusions. This does not include the cost of whole blood, packed red cells, or blood donor fees.
6. devices that are an integral part of a surgical procedure. This includes items such as hip joints, skull plates and pacemakers. It does not include devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids.

"Assistant Surgeon" – a physician trained in the appropriate surgical specialty who serves as the first assistant to another surgeon during a surgical procedure. When medically appropriate, the service of only one assistant per procedure is covered under the Plan.

"Attempt" – the initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:

- commencement of drug therapy to induce ovulation; or
- operative procedures for the purpose of implantation of a fertilized ovum.

"Cardiac Rehabilitation Program" – a recognized, multi-disciplinary program operated by a licensed facility that treats cardiovascular disease through cardiac rehabilitation treatment. The program must meet the generally accepted standards of cardiac rehabilitation.

"Cardiac Rehabilitation Treatment" – treatment of documented cardiovascular disease by a cardiovascular rehabilitation program that includes exercise and diet management to improve cardiovascular function.

"Cognitive Rehabilitation or Cognitive Therapy" – treatment to restore function or minimize effects of cognitive deficits, including but not limited to those related to thinking, learning and memory.

"Complex Procedures/High Risk Maternity Care" – select inpatient surgical procedures designated by the Plan or high-risk pregnancy care for which significant clinical experience is likely to enhance the quality of care. The Plan has also specified certain hospitals that meet experience parameters in terms of patient volume for each of these procedures. For those procedures performed in the corresponding specified hospitals, services are covered at the lower member deductibles and copays.

"Coronary Artery Disease Secondary Prevention Program" – an approved established program for individuals with a diagnosis of coronary artery disease, offered by a specialized interdisciplinary team of clinicians, designed to reduce the effects of heart disease by lifestyle change, diet control, exercise, stress reduction and group support.

"Cosmetic Procedures/Services" – Cosmetic services are those services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered, even if they are intended to improve a member's emotional outlook or treat a member's mental health condition.

"Custodial Care" – a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

"Dependent" –

1. The legal spouse (or the former spouse if authorized by the GIC) of the covered employee or retiree
2. The child of a covered employee, retiree or surviving spouse by birth, legal adoption (upon placement of the child in the home), under custody pursuant to a court order, or under legal guardianship until the age of 19 years
3. A child who depends upon and lives with the covered employee, retiree or surviving spouse and for whom there is evidence of a regular parent-child relationship satisfactory to the GIC, until the age of 19 years
4. An unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC
5. A dependent age 19 or over, but under age 26, who qualifies as a dependent under the Internal Revenue Code
6. A dependent age 19 or over until the earlier of two years following the loss of dependent status under the Internal Revenue Code or age 26, whichever comes first
7. A full-time student, as determined by the GIC, until age 26. At age 26, a full-time student may elect to continue coverage as an individual under the UniCare State Indemnity Plan and pay 100% of the required premium. That student must file a written application with the GIC, and the application must be approved by the GIC, or
8. A newborn child of a covered employee's, retiree's or surviving spouse's dependent son or daughter until the parent of such child ceases to be a dependent of such covered person, or the date the newborn child ceases to be a dependent, whichever occurs first.

"Designated Hospital" – a hospital designated by the Plan for which the benefits are covered at a higher level for certain services, specifically: complex procedures, high-risk maternity care and transplants.

"Durable Medical Equipment" – equipment designed primarily for therapeutic purposes or to extend function that can stand repeated use and is medically necessary and prescribed by a physician. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment. Personal items related to activities of daily living such as commodes and shower chairs are not covered.

"Early Intervention Services" – medically necessary services that include occupational, physical and speech therapy, nursing care and psychological counseling for children from birth until their third birthdays. These services must be provided by persons licensed or certified under Massachusetts law, who are working in Early Intervention programs approved by the Department of Public Health.

"Emergency" – An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child. Emergency treatment does not include Urgent Care. Emergency treatment may be rendered in a hospital, physician's office or other medical facility.

"Enrollee" – an employee, retiree or survivor covered by the GIC's health benefits program who is enrolled in the Plan.

"Enteral Therapy" – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Enteral formulas are not covered under the medical plan. Prescription and nonprescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

"Experimental or Investigational Procedure" – a service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

"Family Planning Services" – office visits and procedures for the purpose of contraception. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan.

"Home Health Care" – health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis. Such services and supplies must be provided in a person's place of residence (not an institution) while the person is confined as a result of injury, disease or pregnancy. To be considered for coverage, Home Health Care must be delivered by a Home Health Care Agency certified by Medicare.

"Home Health Care Plan" – a plan of care for services in the home ordered in writing by a physician. A Home Health Care Plan is subject to review and approval by the Plan.

"Home Infusion Company" – a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

"Home Infusion Therapy" – the administration of intravenous, subcutaneous or intramuscular therapies provided in the home setting. Subcutaneous and intramuscular drugs are available through your prescription drug plan.

"Hospice" – a public agency or a private organization that provides care and services for terminally ill persons and their families and is certified as such by Medicare.

"Hospital" – an institution that meets all of the following conditions:

1. is operated pursuant to law for the provision of medical care
2. provides continuous 24-hour-a-day nursing care
3. has facilities for diagnosis
4. has facilities for major surgery

5. provides acute medical/surgical care or acute rehabilitation or care
6. is licensed as an acute hospital, and
7. has an average length of stay of less than 25 days

The term "Hospital" includes freestanding ambulatory surgical centers operating pursuant to law.

The term "Hospital" does not include:

(a) rest homes
(b) nursing homes
(c) convalescent homes
(d) places for custodial care
(e) homes for the aged

Also see definition for "Other Inpatient Facilities."

"Hospital Stay" – the time a person is confined to a hospital and incurs a room and board charge for inpatient care other than custodial care.

"Incurred Date" – the date a service or supply is provided.

"Infertility" – the condition of a healthy individual who is unable to conceive or produce conception during a period of one year, except if this condition is the result of voluntary sterilization or the normally occurring aging process.

"Injury" – bodily injury sustained accidentally by external means.

"Manipulative Therapy" – hands-on treatment provided by a chiropractor, osteopath or physician by means of direct manipulation or movement to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system. See Exclusions 32 and 33 in the Exclusions section for examples of manipulative therapies that are not covered.

"Medically Necessary" – with respect to care under the Plan, means that the treatment will meet at least the following standards:

1. is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific member's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent ICD-9CM)
2. is reasonably expected to improve or palliate the member's illness, condition or level of functioning
3. is safe and effective according to nationally accepted standard clinical evidence generally recognized by medical professionals and peer-reviewed publications
4. is the most appropriate and cost-effective level of care that can safely be provided for the specific member's diagnosed condition, and
5. is based on scientific evidence for services and interventions that are not in wide-spread use

Note: The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it "Medically Necessary" or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.

"Medical Supplies or Equipment" – disposable items prescribed by physicians as medically necessary to treat disease and injury. Such items include surgical dressings, splints, and braces.

"Member" – an enrollee or his/her dependent who is enrolled in the Plan.

"Non-Experimental Infertility Procedure" – a procedure recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

"Nursing Home" – an institution that:

1. provides inpatient skilled nursing care and related services; and
2. is licensed in any jurisdiction requiring such licensing; but
3. does not qualify as a Skilled Nursing Facility (SNF) as defined by Medicare.

A home, facility or part of a facility does not qualify as a SNF or nursing home if it is used primarily for:

1. rest
2. the care of drug abuse or alcoholism
3. the care of mental diseases or disorders
4. custodial or educational care

"Occupational Injury/Disease" – an injury or disease that arises out of and in the course of employment for wage or profit (see Exclusions on page 47).

"Occupational Therapy" – Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include: treatment programs aimed at improving the ability to carry out activities of daily living; comprehensive evaluations of the home; and recommendations and training in the use of adaptive equipment to replace lost function.

"Off Label Use of a Prescription Drug" – the use of a drug that does not meet the prescribed indications as approved by the Food and Drug Administration (FDA).

"Orthotic" – an orthopedic appliance or apparatus used to support, align or correct deformities and/or to improve the function of movable parts of the body. An orthotic must be ordered by a physician, be custom fabricated (molded and fitted) to the patient's body, and be for use by that patient only.

"Other Inpatient Facilities" – includes the following hospitals/facilities:

1. skilled nursing facilities
2. chronic disease hospitals/facilities
3. transitional care hospitals/facilities
4. sub-acute care hospitals/facilities
5. long-term care hospitals/facilities
6. any inpatient facility with an average length of stay greater than 25 days

"Physical Therapy" – hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relive pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. For examples of non-covered physical therapy services, see Exclusions 32 and 33 in the Exclusion section.

"Physician" – the term "physician" includes the following health care providers acting within the scope of their licenses or certifications:

1. physician
2. podiatrist
3. chiropractor
4. certified nurse midwife
5. dentist
6. optometrist

"Physician Tiering" – a program implemented by the Plan as part of the GIC's Clinical Performance Improvement (CPI) Initiative, whereby Massachusetts physicians are assigned to different tiers based on an extensive evaluation of both their quality and cost-efficiency.

"PLUS Provider" – includes physicians, hospitals and health care providers in Massachusetts. Members who live in Connecticut, Maine, New Hampshire and Rhode Island also have access to PLUS providers in their state. All of these providers must meet strict requirements to be part of this network. PLUS providers include Preferred Vendors listed in the PLUS Provider Directory (see definition in this section).

"Preferred Vendor" – a provider contracted by the Plan to provide certain services or equipment, including but not limited to lab services or durable medical equipment. When you use these PLUS providers, you receive these services at a higher benefit level than when you use other providers for these services.

"Prostheses" – items that replace all or part of a bodily organ or limb and that are medically necessary and are prescribed by a physician. Examples include breast prostheses and artificial limbs.

"Reasonable and Customary Allowed Amount" – The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This allowed amount may not be the same as the provider's actual charge. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

"Reasonable and Customary Charge" – a charge that does not exceed the general level of charges being made by others in a given geographic area where the charge is incurred when furnishing like or similar treatment, services or supplies.

"Reconstructive and Restorative Surgery" – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by one of the following:

- a congenital anomaly, or
- a previous surgical procedure or disease

Restoration of a bodily organ that is surgically removed during treatment of cancer must be performed within five (5) years of surgical removal.

"Respite Care" – services rendered to a hospice patient in order to relieve the family or primary care person from caregiving functions.

"Skilled Care" – medical services that can only be provided by a registered or certified professional health care provider.

"Skilled Nursing Facility (SNF)" – an institution that:

1. is operated pursuant to law
2. is licensed or accredited as a skilled nursing facility if the laws of the jurisdiction in which it is located provide for the licensing or the accreditation of a skilled nursing facility
3. is approved as a skilled nursing facility for payment of Medicare benefits or is qualified to receive such approval, if requested
4. is primarily engaged in providing room and board and skilled nursing care under the supervision of a physician
5. provides continuous 24-hour-a-day skilled nursing care by or under the supervision of a registered nurse (RN), and
6. maintains a daily medical record of each patient

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. rest
2. the care of mental diseases or disorders
3. the care of drug abuse or alcoholism, or
4. custodial or educational care

"Spouse" – the legal spouse of the covered employee or retiree.

"Surgical Procedure" – any of the following types of treatment:

1. a cutting procedure
2. the suturing of a wound
3. the treatment of a fracture
4. the reduction of a dislocation
5. radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
6. electrocauterization
7. diagnostic and therapeutic endoscopic procedures
8. injection treatment of hemorrhoids and varicose veins, and
9. an operation by means of laser beam

"Temporomandibular Joint (TMJ) Disorder" – a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

"Terminal Illness" – an illness that, if it runs its course, is associated with a life expectancy of six months or less.

"Tiers" – different levels into which the Plan groups physicians and hospitals based upon an evaluation of cost, how efficiently they use their resources and whether they meet certain quality measures.

"Travel Access Providers" – UniCare providers that are available to members when traveling outside their home state. When you use these providers, you are not balance billed for your care.

"Urgent Care" – treatment that is provided as soon as the treatment can be arranged, but the treatment is not immediately necessary to prevent death or permanent impairment. Urgent Care does not qualify as emergency treatment.

"Visiting Nurse Association" – an agency certified by Medicare that provides part-time, intermittent skilled nursing services and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.

"Written Proof" – satisfactory proof, in writing, of the incurral of a claim.

This section describes the enrollment process for you and your eligible dependents; when coverage begins and ends; and continuing coverage when eligibility status changes.

Application for Coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

To enroll newborns: You must enroll a child within 31 days of the child's birth. Active employees should see their GIC Coordinator to add the child to their health insurance coverage. Retirees must submit a written request for coverage to the GIC and include a copy of the child's birth certificate.

To enroll or add your dependents: You must enroll each additional dependent when he or she becomes eligible. If you marry, you must enroll your spouse within 31 days of the marriage.

To enroll adopted children: Adopted children must be enrolled within 31 days of placement in the home. Send a written request to the GIC along with a letter from the adoption agency that states the date the child was placed in the home.

Continued dependent coverage: A dependent child who reaches age 19 is no longer automatically eligible for coverage. In order to continue coverage for a dependent age 19 and over, you must complete all of the following steps:

1. Complete the application that will be sent to you by the GIC prior to the dependent's 19th birthday. Return the completed application as instructed on the form. If the application is returned late, your dependent may have a gap in coverage.
2. Complete subsequent eligibility recertification forms that will be sent to you by the GIC. Return the completed forms as instructed on the form. If the forms are returned late, your dependent may have a gap in coverage.

When Coverage Begins

Coverage under the Plan starts as follows:

For new employees: Coverage begins on the first of the month following 60 days or two calendar months of employment, whichever is less.

For persons applying during an annual enrollment period: Coverage begins on the following July 1.

For dependents: Coverage begins on the later of:

1. the date your own coverage begins, or
2. the date the person qualifies as your dependent

For new retirees, spouses and surviving spouses: You will be notified by the GIC of the date on which coverage begins.

Continued Coverage

Your eligibility for these benefits continues if you are:

1. an employee of the Commonwealth, a municipality or other entity that participates in the GIC
2. a retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is not eligible for Medicare
3. a surviving spouse who is not eligible for Medicare
4. a retiree with Medicare who is not eligible for the UniCare State Indemnity Plan/ Medicare Extension
5. the spouse of a retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B but you are not eligible for Parts A and B in your own right

When Coverage Ends for Enrollees

Your coverage ends on the earliest of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the end of the month in which you cease to be eligible for coverage
3. the date the enrollment period ends
4. the date of death
5. the date the survivor remarries, or
6. the date the UniCare State Indemnity Plan terminates

When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. the date your coverage under the UniCare State Indemnity Plan/PLUS ends
2. the end of the month covered by your last contribution toward the cost of such coverage
3. the date you become ineligible to have dependents covered
4. the date the enrollment period ends
5. the date the dependent ceases to qualify as a dependent
6. the date that the dependent child who is permanently and totally disabled and became so by age 19 marries and is no longer eligible for coverage as an IRS or non-IRS dependent
7. the date the dependent begins active duty in the armed forces of the United States
8. the date the divorced spouse remarries (or the date the enrollee marries, depending on the divorce decree)
9. the date of dependent's death, or
10. the date the UniCare State Indemnity Plan terminates

Duplicate Coverage

No person can be covered by any other GIC health plan at the same time as:

1. both an employee, retiree or surviving spouse and a dependent, or
2. a dependent of more than one covered person (employee, retiree, spouse or surviving spouse)

Special Enrollment Condition

If you have declined the UniCare State Indemnity Plan for your spouse or for your dependents because they have other health coverage, you may be able to enroll them during the Plan year if the other coverage is lost. To obtain the appropriate enrollment forms:

- Active Enrollees: check with your GIC Coordinator
- Retirees: contact the GIC

Continuing Coverage

The following provisions in this section explain how coverage may be continued or converted if eligibility status changes.

Continuing Health Coverage Due to Involuntary Layoff

If you are no longer eligible for coverage due to involuntary layoff, you may have coverage under the UniCare State Indemnity Plan/PLUS continued for 39 consecutive weeks. This coverage would apply to you and all of your dependents who are covered under the UniCare State Indemnity Plan at the time you are laid off.

In the event of involuntary layoff, the person who has the option to continue coverage must:

1. elect to continue coverage, in writing, within 30 days after the date eligibility for coverage ends, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. the end of the month of 39 consecutive weeks following the date you cease to be eligible for coverage
2. the end of the month covered by the last contribution toward the cost of your coverage
3. the date the coverage ends
4. the date the UniCare State Indemnity Plan/ PLUS terminates, or
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage

Option to Continue Coverage as a Deferred Retiree

You are eligible for deferred retirement if you:

1. have 10 or more years of full-time service (as determined by the State Retirement Board or your retirement board), and
2. are eligible for a pension from the State Retirement Board or your retirement board, and
3. are leaving your retirement monies in your retirement system

The person who chooses to continue health coverage as a deferred retiree must:

1. contact the GIC for enrollment information, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earlier of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the date the coverage ends
3. the date the UniCare State Indemnity Plan terminates, or
4. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage
5. the date you withdraw your monies from the retirement system

Continuing Health Coverage for Survivors

In the event of your death, your surviving spouse may continue coverage for himself or herself and all dependents covered under the UniCare State Indemnity Plan. If you have no surviving spouse, then your surviving dependent child or children may have such coverage continued until age 19.

To continue coverage, the person who has the option to continue coverage must:

1. elect to continue coverage, in writing within 30 days after the date of your death, and
2. make the required contribution toward the cost of the coverage

Coverage for survivors will end on the earliest of these dates:

1. the end of the month in which the survivor dies
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date the coverage ends
4. the date the UniCare State Indemnity Plan terminates
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent, or
6. the date the survivor remarries

Option to Continue Coverage after a Change in Marital Status

Your spouse will not cease to qualify as a dependent solely because a judgment of divorce or of separate support is granted. If that judgment is granted while the former spouse is covered as a dependent and states that coverage for the former spouse will continue, that person will continue to qualify as a dependent under the UniCare State Indemnity Plan, provided family coverage continues and neither party remarries.

If you get divorced, you must notify the GIC and send them a copy of your divorce decree. If you or your former spouse remarry, you must also notify the GIC.

The former spouse will no longer qualify as a dependent after the earliest of these dates:

1. the end of the period specified in the judgment during which that person must remain eligible for coverage
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date that person remarries
4. the date you remarry. If that person is still covered as a dependent on this date, and the judgment gives that person the right to continue coverage at full cost after you remarry, then that person may either elect to:

   (a) remain covered separately for the benefits for which he or she was covered on that date

   (b) take COBRA coverage, or

   (c) have a converted policy issued to provide those benefits

For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.

Group Health Continuation Coverage under COBRA

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA coverage?

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at www.dol.gov/ebsa.

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth, municipality or other entity ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured's death or divorce—occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- Your employer no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?

Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced
  - The employee or former employee dies
  - The employee divorces or legally separates
  - The employee or employee's former spouse remarries
  - A covered child ceases to be a dependent
  - The Social Security Administration determines that the employee or a covered family member is disabled, or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Conversion to Non-Group Health Coverage

Under certain circumstances, a person whose UniCare State Indemnity Plan/PLUS coverage is ending has the option to convert to non-group health coverage provided by UniCare.

A certificate for this non-group health coverage issued by UniCare can be obtained if:

1. employment for coverage purposes ends, except due to retirement, or
2. status changes occur for someone who is not eligible for continued coverage under the UniCare State Indemnity Plan/PLUS

You cannot obtain a certificate of coverage if you are otherwise eligible under the UniCare State Indemnity Plan/PLUS, or if your coverage terminated for failure to make a required contribution when due. In addition, no certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under the UniCare State Indemnity Plan/PLUS because your health coverage ends, and any child of yours born within 31 days after such coverage ends.

A certificate of coverage is also available to the following persons whose coverage under the UniCare State Indemnity Plan/PLUS ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the UniCare State Indemnity Plan/PLUS solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents, if their coverage ceases because of a change in marital status

The following rules apply to the issuance of the certificate of coverage:

1. Written application and the first premium must be submitted within 31 days after the coverage under the UniCare State Indemnity Plan/PLUS ends.
2. The rules of UniCare for coverage available for conversion purposes at the time application for a certificate of coverage is received govern the certificate. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable, and all other terms and conditions of such certificate.
3. If delivery of the certificate is to be made outside of Massachusetts, it may be on such form as is offered in the state where such certificate is to be delivered.
4. The certificate of coverage will become effective on the day after coverage under the UniCare State Indemnity Plan/PLUS ends.
5. No evidence of insurability will be required.

UniCare will furnish details of converted coverage upon request.

PRESCRIPTION DRUG PLAN

Description of Benefits

Administered by

EXPRESS SCRIPTS®

Description of Benefits

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan.

If you have any questions about your prescription drug benefits, contact the Express Scripts Customer Service Call Center toll free at (877) 828-9744 (TDD: (800) 855-2881).

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter version of Prilosec (Prilosec OTC), medications are covered only if a prescription is required for their dispensing. Diabetic supplies and insulin are also covered by the plan.

The plan categorizes medications into five major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Preferred Brand Name Drugs

A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Non-Preferred Brand Name Drugs

A non-preferred brand name drug, or non-formulary drug, is a medication that usually has an alternative therapeutically-equivalent drug available.

Specialty Drugs

Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

Copayments

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Copayment for	Participating Retail Pharmacy up to 30-day supply	Home Delivery up to 90-day supply
Tier 1 **Generic Drugs and** ▪ Prilosec OTC *(28-day supply – retail; 84-day supply – mail)**	$7	$14
Tier 2 **Preferred Brand Name Drugs**	$20	$40
Tier 3 **Non-Preferred Brand Drugs and** ▪ COX-2 inhibitors *(pain and inflammation-Celebrex)*	$40	$90
Value Tier ▪ Generic Statin *(cholesterol lowering – lovastatin)* ▪ Generic H-2 antagonists *(acid blockers – cimetidine 300, 400 and 800mg; famotidine 40mg; nizatidine 150 and 300 mg; ranitidine 300mg)*	$2	$4
Copayment for	**Specialty Drugs – Must Be Filled Only Through CuraScript**	
Specialty Drugs	$10 up to a 30-day supply	

*Due to manufacturer packaging

How to Use the Plan

Filling Your Prescriptions

You may fill your prescriptions at a participating retail pharmacy or through Express Scripts Home Delivery (Mail Order). Prescriptions for specialty drugs must be filled through CuraScript.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts ID card, with the exception of the limited circumstances detailed in the "Claim Forms" subsection.

Short-Term Medication Needs – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts ID card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online at www.express-scripts.com or by calling toll free at (877) 828-9744.

If you do not have your ID card, you can provide your pharmacist with the cardholder's Social Security or GIC ID number, and the group number, which is GICA. The pharmacist will also be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk toll free at (800) 824-0898 (TDD: (800) 842-5754).

Long-Term Medication Needs

Filling Your Prescriptions Through the Express Scripts Pharmacy

Home Delivery (Mail Order) is your best option for prescription drugs that you take on a regular basis for conditions such as asthma, heartburn, high-blood pressure, allergies and high-cholesterol. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection.

Convenient for You

You get up to a 90-day supply of your medications—which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using Home Delivery, you can order refills online, by phone or by mail.

Using Home Delivery

To begin using Home Delivery for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a Home Delivery order form. (You can obtain a Home Delivery order form and envelope anytime online at www.express-scripts.com or by calling toll free at (877) 828-9744).
3. Put your prescription, payment and completed order form into the mail order envelope and mail it to Express Scripts.

Your prescription drug will be mailed to your home in 10 to 14 business days from the day you mailed the prescription to Express Scripts, with no charge for standard U.S. Postal Service delivery. You can request overnight delivery for an additional charge.

A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay in filling the prescription. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will then apply.

Express Scripts' Specialty Pharmacy

CuraScript is a full-service specialty pharmacy that provides personalized care to each patient. All specialty drugs must be filled through CuraScript pharmacy. Your copayment for these drugs is $10 for up to a 30-day supply. You are allowed two fills of your specialty drug(s) at a participating retail pharmacy. After these two fills, your specialty drug(s) will no longer be covered through other pharmacies.

CuraScript offers a complete range of services and specialty drugs—many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer all of your specialty drug questions. A patient care coordinator will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CuraScript, call CuraScript toll free at (866) 848-9870.

CuraScript Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office or other approved location
- **Refill Reminders** – Ongoing refill reminders from a patient care coordinator
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CuraScript serves a wide range of patient populations, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, post-transplant needs and more.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts ID Card, are covered as follows:

Type of Claim	Reimbursement
Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.*	Claims will be reimbursed at the full cost submitted less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without an Express Scripts ID card.	Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

*Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

Visit express-scripts.com

Get the Information You Need When You Need It

Express-scripts.com provides 24-hour online access to information regarding your prescription benefit. Visit the website to:

- Find out about your copayment amounts
- Verify coverage for eligible dependents
- View or print a list of drugs included in your formulary
- Locate participating retail pharmacies near you
- Review your 12-month prescription history
- Order refills online
- Check the status of your mail order prescription

Register Now to Access express-scripts.com

Accessing your prescription benefit online is quick, easy and secure; just go to www.express-scripts.com and complete a brief registration process to get started. You'll have the information you need about your prescription benefits, right at your fingertips.

Other Plan Provisions

Generics Preferred

Generics Preferred is a program that encourages the use of generic drugs. There are some brand name drugs, such as Zocor and Prinivil, for which generic equivalents are available. If you fill a prescription for a brand-name medication for which there is a generic equivalent, the standard generic copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment.

Prior Authorization

Some drugs on your plan require prior authorization. If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call (800) 417-8164.

Drugs that currently require Prior Authorization*

- Actiq
- Aralast
- Aranesp
- Amevive
- Botox
- Enbrel
- Epogen
- Fentora
- Forteo
- Growth Promoting Agents
- Humira
- Kineret
- Lamisil
- Myobloc
- Orencia
- Penlac
- Procrit
- Prolastin
- Raptiva
- Regranex
- Remicade
- Revatio
- Somavert
- Sporanox
- Tazorac
- Topamax
- Vfend
- Weight Loss drugs such as Xenical and Merida
- Xolair
- Zemaira
- Zonegran

For members over the age of 35: Retin-A, Retin-A Micro, Avita, Tretin-X, Atralin gel, topical tretinoin, Ziana

Quantity Per Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- The manufacturer's recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As otherwise determined by your plan

Examples of drugs with quantity limits currently include Actonel, Avandia, Flonase, Imitrex, Lunesta, Levitra, and Viagra.*

*This list may change during the plan year.

Step Therapy

In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within the previous 160 days, allowing the more-expensive medication to be approved without delay.

If you have not had a medication filled within the previous 160 days while a member of this plan, it is not considered a current prescription and the Step Therapy requirements will apply to your prescription.

In certain situations, a member may be granted an authorization for a second-line prescription drug without the prior use of a first-line prescription drug if specific medical criteria have been met.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will list alternative, first-line drugs that could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using Home Delivery, Express Scripts will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, Express Scripts will not fill your prescription and will return it to you.

Current examples of second-line prescription drugs requiring Step Therapy*	
ADD/ADHD	Strattera
Allergies	Accolate, Clarinex, Nasacort AQ, Rhinocort Aqua, Singulair, Xyzal and Zyflo
Antidepressants	Celexa, Cymbalta, Effexor XR, Lexapro, Paxil CR and Zoloft
Antipsychotic	Symbyax
High-Blood Pressure	Accupril, Aceon, Altace, Atacand/HCT, Avapro, Avalide, Cardene, Coreg, Cozaar/HCT, Diovan/HCT, Lexxel, Lotrel, Mavik, Micardis/HCT, Monopril/HCT, Norvasc, Sular, Tarka, Teveten, Toprol XL and Uniretic
High-Cholesterol	Caduet, Lescol, Lipitor and Zetia
Insomnia	Ambien CR, Lunesta, Rozerem and Sonata
Neuropathy	Lyrica
Pain/Arthritis	Arthrotec, Celebrex, Ponstel and Mobic
Stomach Ulcers	Aciphex, Nexium, Prevacid and Protonix
Topical Dermatitis	Elidel and Protopic

*This list may change during the plan year.

Drug Utilization Review Program

Each prescription drug purchased through this program is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the program;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

Exclusions

Benefits exclude:*

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Prilosec OTC)
- Vitamins or minerals prescribed in the absence of certain medical conditions (with the exception of prenatal vitamins)
- Homeopathic drugs
- Prescriptions for cosmetic purposes
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Allergens
- Hair growth agents
- Prescription drugs with over-the-counter (OTC) equivalents with the same strengths, routes of administration, active chemical ingredients and dosage forms as the prescription drug products
- Special medical formulas or food products, except as required by state law.

Definitions

Brand Name Drug – The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Diabetic Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and preferred brand name products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in either the retail pharmacy or mail service settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

*This list may change during the plan year.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The U.S. Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Non-Preferred Brand Name Drug – A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the Express Scripts Pharmacy and Therapeutics Committee, which determined that an alternative drug that is clinically equivalent and more cost effective may be available.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand Name Drugs – A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug also includes insulin and diabetic supplies.

Prior Authorization – Prior authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to $2,500 per calendar year per member. To access the benefit for special medical formulas or food products, members must first call the Group Insurance Commission at (617) 727-2310, extension 1.

Specialty Drugs – Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

Other Plan Information

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center toll free at (877) 828-9744 (TDD: (800) 855-2881).

Health and Prescription Information

Health and prescription information about members is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

UNITED BEHAVIORAL HEALTH

Description of Benefits

Part I—How to Use This Plan

A Comprehensive Plan Designed With Your Well-Being In Mind

As a covered person under the UniCare State Indemnity Plan, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services—from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child- and elder-care referrals) to more serious mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) administers the benefits under this program on behalf of the Group Insurance Commission (GIC). With a proven track record of providing EAP services and managing care for more than 43 million people, UBH can successfully meet the diverse needs of UniCare State Indemnity Plan covered persons.

United Behavioral Health will be Branded as OptumHealth Behavioral Solutions

Effective January 1, 2009, UBH will be operating under the brand name of OptumHealth Behavioral Solutions. This new brand name illustrates their continuing mission to optimize the health and well-being of GIC members.

Please note that this is only a brand name, and it will not affect any of their operations and procedures as described in this handbook. Their corporate entity is still registered as United Behavioral Health.

Let Us Show You The Benefits

The following describes your mental health, substance abuse and EAP benefits under the UBH/OptumHealth Behavioral Solutions plan. Please read it carefully before you seek care to ensure that you receive maximum benefits. The chart on pages 86–87 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 88–92. Words in italics throughout this description are defined in the "Definitions" section in Part II.

How to Ensure Maximum Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: Call UBH/OptumHealth Behavioral Solutions for *precertification* before you seek EAP, mental health or substance abuse services; and

Step 2: Use a provider or facility from the UBH/OptumHealth Behavioral Solutions network.

UBH/OptumHealth Behavioral Solutions offers you a comprehensive network of resources and experienced providers from which to obtain EAP, mental health and substance abuse services. All UBH/OptumHealth Behavioral Solutions *network providers* have been reviewed by UBH/OptumHealth Behavioral Solutions for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH/OptumHealth Behavioral Solutions network, your benefit level will be lower than the network level. These reduced benefits are defined as *out-of-network benefits*. If you fail to call UBH/OptumHealth Behavioral Solutions to *precertify* your care, you may be charged a penalty and your benefits may be reduced. In some cases if you fail to *precertify* your care, no benefits will be paid. Please refer to Part III, titled **Benefits Explained**, on pages 88–92, for a full description of your *network* and *out-of-network* benefits, as well as special

Words in italic are defined in Part II.

precertification requirements for certain *out-of-network* outpatient services. **Benefits will be denied if your care is considered not to be a covered service.**

Before You Use Your Benefits

Precertification

Precertification is the first step to obtaining your EAP, mental health and substance abuse benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489).

A trained UBH/OptumHealth Behavioral Solutions clinician will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All UBH/OptumHealth Behavioral Solutions clinicians are experienced professionals with master's degrees in psychology, social work, or a related field. A UBH/OptumHealth Behavioral Solutions clinician will immediately be available to assist you with routine matters or in an emergency. If you have specific questions about your benefits or claims, call a customer service representative from 9 a.m. to 8 p.m. Eastern Time at (888) 610-9039 (TDD: (800) 842-9489).*

Based on your specific needs, the UBH/OptumHealth Behavioral Solutions clinician will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your request (e.g., provider location, gender, or fluency in a second language). UBH/OptumHealth Behavioral Solutions maintains an extensive database of information on every provider in the network. (A directory of UBH/OptumHealth Behavioral Solutions providers can be found on the UBH/OptumHealth Behavioral Solutions web site, liveandworkwell.com (access code 10910). After *precertification*, you can then call the provider directly to schedule an appointment. **If you need assistance, a UBH/OptumHealth Behavioral Solutions clinician can help you in scheduling an appointment.** The UBH/OptumHealth Behavioral Solutions clinician can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must call UBH/OptumHealth Behavioral Solutions **within 24 hours** of an emergency admission to notify UBH/OptumHealth Behavioral Solutions of the admission. Although a representative may call on your behalf, it is always the covered person's responsibility to ensure that UBH/OptumHealth Behavioral Solutions has been notified. If UBH/OptumHealth Behavioral Solutions is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied. UBH/OptumHealth Behavioral Solutions staff is available 24 hours a day to assist you and/or your covered family members.

Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, our providers will have an appointment to see you within 24 hours of your initial call to UBH/OptumHealth Behavioral Solutions.

*As part of UBH's/OptumHealth Behavioral Solutions' quality control program, supervisors monitor random calls to UBH's/OptumHealth Behavioral Solutions' customer services department, but not the clinical department.

Words in italic are defined in Part II.

Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *network providers* will have appointments to see you within three days of your initial call to UBH/OptumHealth Behavioral Solutions.

Enrollee Assistance Program

Your Enrollee Assistance Program benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g. international events, community trauma). The EAP can also provide critical incident response and on-site behavioral health consultation for State agencies and municipalities.

Confidentiality

When you use your EAP, mental health and substance abuse benefits under this plan, you are consenting to the release of necessary clinical records to UBH/OptumHealth Behavioral Solutions for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH/OptumHealth Behavioral Solutions only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health and substance abuse benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH/OptumHealth Behavioral Solutions staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your EAP, mental health and substance abuse benefits. UBH/OptumHealth Behavioral Solutions staff must comply with a strict confidentiality policy.

Complaints

If you are not satisfied with any aspect of the UBH/OptumHealth Behavioral Solutions program, we encourage you to call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489) to speak with a customer service representative. The UBH/OptumHealth Behavioral Solutions member services representative resolves most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at UBH/OptumHealth Behavioral Solutions, including clinicians, claims representatives, administrators, and other management staff who report directly to senior corporate officers. We will respond to all inquiries within three business days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal *complaint* in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with UBH/OptumHealth Behavioral Solutions and include any information you feel is relevant. Formal *complaints* will be responded to in writing within 30 days. A formal *complaint* should be sent to:

United Behavioral Health
Complaint Unit
100 East Penn Square
Suite 400
Philadelphia, PA 19107

Words in italic are defined in Part II.

Appeals

Your Right to an Internal Appeal

You, your treating provider, or someone acting on your behalf have the right to request an *appeal* of the benefit decision made by UBH/OptumHealth Behavioral Solutions. You may request an *appeal* in writing by following the steps below.

If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase the risk to your health, could result in severe pain, or could impact your ability to regain maximum function), please see the section entitled "Expedited Internal Appeal Review Process" on page 82.

How to Initiate a First Level Internal Appeal (Non-Urgent Appeal)

Your *appeal* request must be submitted to us within 180 days after the date you received notice of your benefit coverage determination. Written requests should be submitted to the following address:

United Behavioral Health
Appeals Department
100 East Penn Square
Suite 400
Philadelphia, PA 19111
(800) 842-1311 x 5718
Fax Number: (866) 302-4472

Appeal requests must include:

- The patient's name and the identification number from the ID card.
- The date(s) of service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

The First Level Internal Appeal Review Process (Non-Urgent Appeal)

A board certified psychiatrist in the same or similar specialty area as your treating psychiatrist will review and make the decision about your *appeal* request. If your treating provider is not a psychiatrist, a doctoral-level psychologist or a psychiatrist who has not had any previous involvement in your *appeal* case will review and make a decision about your *appeal* request. The UBH/OptumHealth Behavioral Solutions psychiatrist or psychologist will not have had any previous involvement in decisions about your case. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Prior to the *appeal* review, you and your provider have the opportunity to submit any additional information or documentation that you would like to be considered as part of the *appeal* review. Examples of such information are: records relating to the current conditions or treatment, co-existent conditions, or any other relevant information.

UBH/OptumHealth Behavioral Solutions will notify you, or your authorized representative and your provider, of the *appeal* resolution in writing within thirty (30) calendar days of UBH's/OptumHealth Behavioral Solutions' receipt of your *appeal* request. If this is an *appeal* for services you have not yet received, UBH/OptumHealth Behavioral Solutions will complete the review and notify you of the outcome within fifteen (15) calendar days of your request. The notification will include the specific information upon which the determination was based.

How to Initiate a Second Level Internal Appeal (Non-Urgent Appeal)

If you remain dissatisfied with the outcome of the first level *appeal* review, you may request a second level standard *appeal* review. A second level standard *appeal* must be requested within sixty (60) calendar days from the date on your first level *appeal* notification letter you received from UBH/OptumHealth Behavioral Solutions.

The UBH/OptumHealth Behavioral Solutions Appeal Reviewer conducting the review will not have been involved in a prior benefit determination for the treatment episode nor will the Appeal Reviewer be a subordinate of the UBH/OptumHealth Behavioral Solutions reviewer who made previous benefit determinations for the treatment episode. If your *appeal* is related to a clinical benefit coverage determination, the review will be done in consultation with a behavioral health care professional with appropriate expertise in the field, who was not involved in the prior benefit determination.

To request a second level standard *appeal*, contact UBH/OptumHealth Behavioral Solutions at the address listed above. Prior to the *appeal* review being conducted, you and your provider have the opportunity to submit any additional information or documentation that you would like considered as part of the second level *appeal* review. You may also request copies, free of charge, of any relevant documents, records, or other information UBH/OptumHealth Behavioral Solutions used to make its *appeal* decision.

As in the first level *appeal* review, UBH/OptumHealth Behavioral Solutions will notify you, or your authorized representative and your provider of the *appeal* resolution in writing within thirty (30) calendar days of receipt of your *appeal* request. If this is an *appeal* for services you have not yet received, UBH/OptumHealth Behavioral Solutions will complete the review and notify you of the outcome within fifteen (15) calendar days of your request.

Expedited Internal Appeal Review Process

Your *appeal* may require immediate action if a delay in treatment could significantly increase the risk to your health, could result in severe pain, or could impact your ability to regain maximum function. In these urgent situations:

- The *appeal* does not need to be submitted in writing. You or your provider should call us as soon as possible using the phone number under "How to Initiate a First Level Internal Appeal" on page 81.
- An expedited *appeal* will be reviewed, a decision made, and you and your provider notified within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

Third Level Internal Review Process

If you remain dissatisfied with the outcome of the Second Level Appeal review, you may request a third level *appeal* to the Group Insurance Commission. The request must be made in writing to Group Insurance Commission within thirty (30) days of the receipt of the Second Level Appeal outcome letter.

To request a third level *appeal*, contact the Group Insurance Commission at the address listed below:

Appeals Unit
Group Insurance Commission
Commonwealth of Massachusetts
P.O. Box 8747
Boston, MA 02114-8747

Prior to the *appeal* review being conducted, you and your provider have the opportunity to submit any additional information or documentation that you would like considered as part of the appeals review. You may also request copies, free of charge, of any relevant documents, records, or other information UBH/OptumHealth Behavioral Solutions used to make its *appeal* decision.

The Group Insurance Commission will notify you, or your authorized representative and your provider of the *appeal* resolution in writing within thirty (30) calendar days of receipt of your *appeal* request.

Words in italic are defined in Part II.

Filing Claims

Network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all *coinsurance*, and *deductibles*. Send the *out-of-network provider's* itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

United Behavioral Health
Claims
P.O. Box 30755
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH/OptumHealth Behavioral Solutions within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

Coordination of Benefits

All benefits under this plan are subject to coordination of benefits, which determines whether your mental health and substance abuse care is partially or fully covered by another plan. UBH/OptumHealth Behavioral Solutions may request information from you about other health insurance coverage in order to process your claim correctly.

For More Information

UBH/OptumHealth Behavioral Solutions customer service staff is available to help you. Call (888) 610-9039 (TDD: (800) 842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

Part II—Benefit Highlights

Definitions of UBH/OptumHealth Behavioral Solutions Terms

Allowed Charges means charges conform to UBH/OptumHealth Behavioral Solutions negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

Appeal means a formal request for UBH/OptumHealth Behavioral Solutions to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Case Management means a system of *continuing review* by a UBH/OptumHealth Behavioral Solutions clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and a covered service according to the plan of benefits for a covered diagnostic condition.

Coinsurance means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

Complaint means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH/OptumHealth Behavioral Solutions.

Continuing Review/Concurrent Review means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

Words in italic are defined in Part II.

Coordination of Benefits (COB) means a methodology which determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the "primary plan."

Copayment means a fixed dollar amount that a covered person must pay out of his or her own pocket.

Covered Services are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered – Exclusions."

Cross Accumulation means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

Deductible means the designated amount that a covered person must pay for any charges before insurance coverage applies.

Intermediate Care means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

Network Provider is a provider who participates in the UBH/OptumHealth Behavioral Solutions network.

Non-Notification Penalty means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum*.

Out-of-Network Provider is a provider who does not participate in the UBH/OptumHealth Behavioral Solutions network.

Out-of-Pocket Maximum means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum*, all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, charges for out-of-network care that exceed the maximum number of covered days or visits, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a covered service, and charges in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*.

Precertification (Precertify) is the process of registering for services with UBH/OptumHealth Behavioral Solutions prior to seeking EAP, mental health and substance abuse care. All *precertification* is performed by *UBH/OptumHealth Behavioral Solutions clinicians*.

UBH/OptumHealth Behavioral Solutions Clinician refers to the staff member who *precertifies* EAP, mental health and substance abuse services. *UBH/OptumHealth Behavioral Solutions clinicians* must have the following qualifications: Master's degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

Words in italic are defined in Part II.

What This Plan Pays

The Plan pays for the following services:

- **Outpatient Care** – Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** – Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** – A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** – Treatment in a hospital or substance abuse facility.
- **Detoxification** – Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** – Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** – An interactive web site offering a large collection of wellness articles, service databases including a UBH/OptumHealth Behavioral Solutions Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.liveandworkwell.com and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

Words in italic are defined in Part II.

The following chart summarizes certain benefits available to you. Be sure to read Part III, which describes your benefits in detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH/OptumHealth Behavioral Solutions before you begin treatment. For assistance, call 24 hours a day, seven days a week: (888) 610-9039 (TDD: (800) 842-9489).

Covered Services	Network	Out of Network
Annual *Deductible*	None	$150 per person (a,b) $300 per family (a,b)
Out-of-Pocket Maximum	$1,000 per individual (a) $2,000 per family	$3,000 per member (a) No family maximum
Benefit Maximums	Unlimited	Unlimited
Inpatient Care		
Deductible	$200 per calendar quarter (a,c)	$150 per admission (applies after annual *deductible* is met) (a)
Mental Health General Hospital Psychiatric Hospital Substance Abuse General Hospital or Substance Abuse facility	Full coverage Full coverage	80% of *allowed charges*
	All hospital care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. *Non-notification penalty* for failure to precertify care is $200. *Non-notification penalty* does not count toward *out-of-pocket maximums*.	
Intermediate care (d) (Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs)	Full coverage	80% of *allowed charges* after *deductible* is met

Words in italic are defined in Part II.

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (d, e, f, g) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Enrollee Assistance Program (EAP)	Up to 3 visits: 100%	No Coverage for EAP
	EAP *non-notification penalty* reduces benefit to zero: no benefits paid.	
Individual and family therapy	100%, after $15 per visit After $10 copay, full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Group therapy	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Medication Management: (15-30 minute psychiatrist visit.)	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
In-Home Mental Health Care	Full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage	No coverage
	Non-notification penalty reduces benefit to zero: no benefits paid.	
Provider Eligibility – Provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (h)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (h)

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network and out-of-network out-of-pocket maximums* do not *cross accumulate*.
(b) *Cross accumulates* with all *out-of-network* mental health and substance abuse benefit levels.
(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.
(d) Treatment that is not *precertified* receives *out-of-network* level of reimbursement, except as noted in item (g) below.
(e) All *out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.
(f) No *precertification* is required for *out-of-network* outpatient visits 1 through 15 per calendar year.
(g) *Out-of-network* outpatient visits 16 and over, per calendar year, are subject to the same precertification requirement as *network* benefits in order to be eligible for coverage.
(h) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: the words in italic have special meanings that are given in the Glossary section.

Part III—Benefits Explained

Mental Health and Substance Abuse Benefits

Network Services

In order to receive maximum network benefits for EAP, mental health and substance abuse treatment you must call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489) to *precertify* care and obtain a referral to a *network provider*.

Precertified network care has no *deductible*. Covered services are paid at 100% after the appropriate *copayments* (see *copayment* schedule on page 87). The calendar year *out-of-pocket maximum* for network services is $1,000 per individual and $2,000 per family.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties*.
- Cost of treatment subject to exclusions.

If you fail to *precertify* your care, you will be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 86–87, and in the following descriptions of services.

Network Benefits

Outpatient Care – The *copayment* schedule for *network* outpatient *covered services* is shown below:

- Individual and family therapy, all visits: $15 *copayment*
- Medication Management, all visits: $10 *copayment*
- Group Therapy, all visits: $10 *copayment*
- Enrollee Assistance Program, up to 3 visits: No *copayment*

Failure to *precertify* outpatient care results in a benefit reduction to the *out-of-network* level reimbursement, and in some cases, may result in no coverage.

In-Home Care – In-home care is a covered service if *precertified*. Treatment that is *not precertified* but deemed to be a covered service receives out-of-network level reimbursement, and in some cases, may result in no coverage. Please refer to the section titled *Out-of-network* Services below for details.

Intermediate Care – *Intermediate care* is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not pre-certified but deemed to be a covered service receives out-of-network level reimbursement.

Inpatient Care – Network inpatient care deemed to be a covered service in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a $200 per calendar quarter *deductible*. The *deductible* is waived if readmitted within 30 days with a maximum of one *deductible* per calendar quarter. There is a $200 *non-notification penalty* for failure to *precertify* inpatient care.

Drug Testing – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

Psychological Testing – Psychological testing, including neuropsychological testing, that is deemed to be a covered service is covered when *precertified*. Psychological testing that is not *precertified*, yet deemed to be a covered service, receives out-of-network level reimbursement if deemed to be a covered service. It is highly recommended that you obtain *precertification* before initiating psychological testing in order to confirm the extent of your coverage. (Guidelines for coverage of psychological testing can be found on the UBH/OptumHealth Behavioral Solutions web site.)

Words in italic are defined in Part II.

Enrollee Assistance Program

The **Enrollee Assistance Program** can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs
- Aging
- Traumatic events

To use your EAP benefit, call (888) 610-9039 (TDD: (800) 842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by an UBH/OptumHealth Behavioral Solutions clinician to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The UBH/OptumHealth Behavioral Solutions clinician may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

Legal Services

In addition to EAP counseling. Legal assistance is available to enrollees of the UniCare State Indemnity Plan. The UBH/OptumHealth Behavioral Solutions Legal Assistance services give you free and discounted confidential access to a local attorney, who will answer legal questions, prepare legal documents, and help solve legal issues. The services provides:

- Free referral to a local attorney
- Free 30 minute consultation (phone or in-person) per legal matter
- 25% discount for ongoing services
- Free online legal information, including common forms and will kits

For more information or to be connected with UBH/OptumHealth Behavioral Solutions Legal Assistance, call UBH/OptumHealth Behavioral Solutions toll free at (888) 610-9039 (TDD: (800) 842-9489)

Employee Assistance Program

The Commonwealth's Group Insurance Commission also offers an Employee Assistance Program to all agencies and municipalities. Managers and supervisors can receive confidential consultations and resource recommendations for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness, and substance abuse.

Out-of-Network Services

Care from an *out-of-network* provider is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*.

Benefits are paid based on *allowed charges* that are UBH/OptumHealth Behavioral Solutions reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a $150 per person/$300 per family calendar year *deductible*. Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per person.

Words in italic are defined in Part II.

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found to not be a covered service
- Charges in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*

All out-of-network care must be *precertified* with UBH/OptumHealth Behavioral Solutions in order to be eligible for coverage. All *out-of-network* outpatient visits in a calendar year, including mental health, substance abuse and EAP outpatient visits, medication management visits, and in-home mental health care visits, are accumulated to determine the appropriate *out-of-network* level of reimbursement. There are different levels of reimbursement for *out-of-network* outpatient visits 1–15 and visits 16 and over as described below. Also, all *out-of-network* outpatient visits after visit 15 are subject to the same *precertification* requirements as *network* benefits in order to be eligible for coverage. Charges paid by the covered person for *out-of-network* outpatient care, if determined to be a *covered* service and if *precertified* when required, do count toward the *out of pocket maximum*. If it is determined that care was not a covered service, no benefits will be paid.

Out-of-Network Benefits

Outpatient Care – Outpatient visits deemed to be a covered service are paid at 80% of UBH's/OptumHealth Behavioral Solutions' *allowed charges*, up to a maximum of 15 visits per calendar year after your $150/$300 annual *deductible* is met. These initial visits do not require *precertification*. *Out-of-network* outpatient visits after visit 15 that are subject to the same *precertification* requirements as *network* benefits and are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges* if deemed to be a covered service. Out-of-network care utilized to satisfy the annual *deductible* counts toward the 15 visit maximum. Charges paid by the covered person for outpatient out-of-network care in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges* or for sessions after 15 that are not precertified, do not count towards the *out-of-pocket maximum*.

In-Home Care – Included in outpatient care. Visits are covered at 80% for the first 15 visits per calendar year after appropriate annual *deductibles* have been met. Out-of-network outpatient visits after visit 15 that are subject to the same *precertification* requirements as *network* benefits and are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges* if deemed to be a covered service.

Intermediate Care – *Intermediate care* deemed to be a covered service is paid at 80%, after appropriate annual *deductibles* have been met.

Inpatient Care – Out-of-network inpatient care deemed to be a covered service for mental health care or substance abuse treatment is paid at 80% in a general hospital, psychiatric facility, or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH/OptumHealth Behavioral Solutions case manager determines that the care is a covered service. No benefits will be paid if it was found not to be a covered service.

Drug Testing – There is no coverage for out-of-network drug testing.

There is no coverage for *out-of-network* EAP services.

What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's provider and/or the only available treatment options for the Covered Person's condition.

Words in italic are defined in Part II.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH/OptumHealth Behavioral Solutions, are any of the following:
  - — not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - — not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - — not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - — typically do not result in outcomes demonstrably better than other available treatment alternative that are less intensive or more cost effective; or
  - — not consistent with UBH's/OptumHealth Behavioral Solutions' Level of Care Guidelines or best practices as modified from time to time.

  UBH/OptumHealth Behavioral Solutions may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - — it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
  - — it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  - — required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - — ordered by a court except as required by law;
  - — conducted for purposes of medical research; or
  - — required to obtain or maintain a license of any type.

Words in italic are defined in Part II.

- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH/ OptumHealth Behavioral Solutions has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the Covered Person.
- Mental health and substance abuse services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Words in italic are defined in Part II.

APPENDICES

Appendix A: GIC Notices

Appendix B: Disclosure When Plan Meets Minimum Standards (for health insurance coverage in Massachusetts)

Appendix C: List of PLUS Tier 1 and 2 Hospitals in Massachusetts

Appendix D: Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care

Appendix E: Claim Form

Appendix F: Bill Checker Form

Appendix A: GIC Notices

- Notice of Group Insurance Commission Privacy Practices
- Notice about your Prescription Drug Coverage and Medicare
- Important Information from the Group Insurance Commission about Your HIPAA Portability Rights
- The Uniformed Services Employment and Reemployment Rights Act (USERRA)

Notice of Group Insurance Commission Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment Activities – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

Required Disclosures – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal

Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at www.mass.gov/gic).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Your Prescription Drug Coverage and Medicare

Important Notice about Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, is offered through various health plans and other organizations. All Medicare prescription drug plans provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.

- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at (800) 772-1213 (TTY: (800) 325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1 percent per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at (617) 727-2310.

Important Information from the Group Insurance Commission about Your HIPAA Portability Rights

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group health plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at (617) 521-7777 or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272.

Using Certificates of Creditable Coverage to Reduce Pre-existing Condition Exclusion Waiting Periods

Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as "pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior "creditable" coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act [FMLA] and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

When You Have the Right to Specially Enroll in Another Plan

If you lose your group health coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, if you have such a life event or your coverage ends, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You Have the Right Not to Be Discriminated Against Based on Health Status

A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When You Have the Right to Individual Coverage

If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more.
- Your most recent coverage was under a group health plan (shown on this certificate).
- Your group coverage was not terminated because of fraud or nonpayment of premium.
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.

Disclosure When Plan Meets Minimum Standards

*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets the Minimum Creditable Coverage standards** that are effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

List of PLUS Tier 1 and Tier 2 Acute Care Hospitals

There is a $250 deductible per calendar year quarter for inpatient care at all Tier 1 PLUS acute care hospitals located in Massachusetts. See Appendix E for a list of additional hospitals available at the $250 inpatient hospital deductible.

There is a $400 deductible per calendar year quarter for inpatient care at all:

- Tier 2 PLUS hospitals in Massachusetts and
- non-PLUS hospitals

PLUS members residing in Connecticut, Maine, New Hampshire and Rhode Island also have access to additional PLUS hospitals in their state at the $250 inpatient hospital deductible. For listings, log onto www.unicarestateplan.com and under "Find a Provider," click on the link for out-of-state providers only and follow the directions provided. You can also call Customer Service at (800) 442-9300 for assistance.

PLUS Plan Tier 1 Hospitals

Addison Gilbert Hospital
Anna Jaques Hospital
Athol Memorial Hospital
Baystate Franklin Medical Center
Baystate Mary Lane Hospital
Baystate Medical Center
Beth Israel Deaconess Medical Center – Boston
Beth Israel Deaconess Hospital – Needham
Beverly Hospital
Cape Cod Hospital
Caritas Good Samaritan Medical Center
Caritas Norwood Hospital
Charlton Memorial Hospital
Children's Hospital
Clinton Hospital
Cooley Dickinson Hospital
Fairview Hospital
Harrington Memorial Hospital
HealthAlliance Hospital – Fitchburg
HealthAlliance Hospital – Leominster
Heywood Hospital
Lawrence General Hospital
Lawrence Memorial Hospital
Marlborough Hospital
Melrose–Wakefield Hospital
MetroWest Medical Center – Framingham
MetroWest Medical Center – Natick
Morton Hospital and Medical Center
Mount Auburn Hospital
New England Baptist Hospital
Noble Hospital
North Adams Regional Hospital
North Shore Children's Hospital
North Shore Medical Center – Lynn
North Shore Medical Center – Salem
Quincy Medical Center
Saints Memorial Medical Center
St. Luke's Hospital
Tobey Hospital
Winchester Hospital
Wing Memorial Hospital and Medical Centers

PLUS Plan Tier 2 Hospitals

Berkshire Medical Center
Boston Medical Center
Brigham and Women's Hospital
Cambridge Hospital
Caritas Carney Hospital
Caritas Holy Family Medical Center
Caritas St. Elizabeth's Medical Center
Dana–Farber Cancer Institute
Falmouth Hospital
Faulkner Hospital
Jordan Hospital
Lahey Clinic
Lowell General Hospital
Mass Eye and Ear Infirmary
Massachusetts General Hospital
Milton Hospital
Nashoba Valley Medical Center
Newton–Wellesley Hospital
Somerville Hospital
South Shore Hospital
St. Anne's Hospital
The Floating Hospital for Children at Tufts–New England Medical Center
Tufts–New England Medical Center
UMass Memorial Medical Center
Whidden Memorial Hospital

Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care

There is a $250 deductible per calendar year quarter for inpatient care at all PLUS acute care hospitals located in Massachusetts that are designated as Tier 1 in Appendix D of this Handbook. The PLUS Plan also provides access to the following additional hospitals for certain complex procedures at the $250 deductible, as indicated in the chart below. (See page 26 for information about Quality Centers and Designated Hospitals for transplants.)

	Brigham and Women's Hospital	Caritas St. Elizabeth's Medical Center	Lahey Clinic	Massachusetts General	South Shore Hospital	Tufts-New England Medical Center	University of Massachusetts Medical Center
Abdominal Aortic Aneurysm Repair*	▪		▪	▪	▪		▪
Cardiac Valve Procedures	▪		▪	▪			▪
Coronary Artery Bypass*	▪		▪	▪		▪	
Discectomy & Laminectomy	▪		▪	▪			▪
Esophagectomy*	▪		▪	▪	▪		
High Risk Deliveries & Neonatal ICUs*	▪			▪	▪	▪	▪
Hip Replacement	▪		▪	▪			▪
Knee Replacement	▪		▪	▪			▪
Pancreatic Resection*	▪		▪	▪		▪	▪
Percutaneous Coronary Intervention*	▪	▪	▪	▪		▪	▪
Spinal Fusion	▪		▪	▪			▪

* These procedures have been designated by the Leapfrog Group for Patient Safety as complex procedures that studies indicate are most safely performed at hospitals that meet the following criteria: 1) they have significant experience in performing the procedure, and 2) they comply with specific clinical practices established by the Leapfrog Group.

UNICARE LIFE & HEALTH INSURANCE COMPANY
ANDOVER SERVICE CENTER
CLAIMS DEPARTMENT
P.O. BOX 9016
ANDOVER, MA 01810-0916
1-800-442-9300

CONTROL 26585 / 06136 •

SECTION 1: You must complete this section when filing a claim.

Medicare Beneficiary
After Medicare pays its portion of a claim for medical charges, please complete Section 1, attach the explanation of Medicare payment and/or any bill that indicates the total provider charge, the Medicare allowed charge as well as the Medicare payment, and send to UniCare.

Non-Medicare Enrollees:
Please complete Sections 1, 2, and 3 in order to receive prompt reimbursement. Section 4 can be completed by your physician or an itemized bill can be submitted in place of Section 4.

Employee's/Retiree's Name (Please Print) Last	First	MI	Employee's/Retiree's Soc. Sec. No./ID No.
			Employee/Retiree Medicare No.
Employee's/Retiree's Street Address			City, State and Zip Code
			Phone No. ( )

SECTION 2: If you are a Medicare Beneficiary, please stop here.

Your Date of Birth	Male ☐ Female ☐	Marital Status (Check one) ☐ Single ☐ Divorced ☐ Married ☐ Legally Separated
Name of Spouse	Spouse's Date of Birth	Name and Address of Spouse's Employer

Is Claim For Your Spouse/Dependent? ☐ No ☐ Yes	Name of Dependent, If Other Than Spouse	Relationship To You ☐ Child ☐ Stepchild ☐ Other ☐ Spouse	Dependent's Date of Birth	Is Your Dependent Married? ☐ No ☐ Yes Full-Time Student ? ☐ No ☐ Yes Employed Full-Time ? ☐ No ☐ Yes

Date of First Treatment For This Illness or Injury	Name and Address of Doctor (Please Print)

Is This Condition Due to an Injury? ☐ No ☐ Yes	Is This Condition Due to an Occupational Injury or Disease ? ☐ No ☐ Yes	Date of Injury	Where Did it Occur ?
Describe How Accident Happened			

Are You, Your Spouse or Your Dependent Children in Any Other Health Benefit Plan Including Medicare? ☐ No ☐ Yes	If Yes, Name of Member/Subscriber (if different from Patient)	Relationship to Patient	Other Group/Policy/Contract No.
Member/Subscriber Soc. Sec. No.	Name and Address of Other Plan Claim Payment Office		

In consideration of benefit payment under this Group Policy, without reduction for any right of recovery under the Worker's Compensation Act, I assign to the UniCare Life & Health Insurance Company my right, title, and interest to any recovery of Workers' Compensation benefits for this disease or injury, however recovered, to the extent of benefits paid under this Group Policy.

I authorize any physician or other medical professional, hospital or other medical care institution, insurer, medical or hospital service or prepaid health plan, employer or group policyholder, contractholder or benefit plan administrator to disclose to UniCare Life & Health Insurance Company or any plan administrator, consumer reporting agency, or attorney acting on UniCare Life & Health Insurance Company's behalf, any medical information and any employment related information regarding the patient. This information will be used only to evaluate and administer claims for benefits.

This authorization is valid for the duration of the claim.

I know I have a right to receive a copy of this authorization and that a photographic copy is as valid as the original.

Any person who knowingly files a statement of claim containing false, incomplete or misleading information with intent to injure, defraud, or deceive any insurance company is guilty of a crime.

Employee's/Retiree's Signature

Patient Signature, if patient is not employee (Parent, if patient is a minor)

Date

*UniCare does not insure benefits under control number 06136. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan.

SECTION 3	PATIENT INFORMATION	
Patient's Name Last First MI	Patient's Sex ☐ Male ☐ Female	Patient's Relationship to Employee/Retiree ☐ Self ☐ Child ☐ Spouse ☐ Other
Patient's Street Address	Patient's Date of Birth	Was Condition Related To: Patient's Employment ☐ Yes ☐ No An Auto Accident ☐ Yes ☐ No
Other Health Insurance Coverage - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number (including Medicaid, Medicare)	Insured's I.D. No. (S.S. No.)	Insured's Group No. (Or Group Name)
Patient's or Authorized Person's Signature I Authorize the Release of any Medical Information Necessary to Process this Claim X	Insured's Name	
The GIC Indemnity Plan will pay benefits directly to the provider unless a receipted bill is attached	Insured's Address	

SECTION 4	PHYSICIAN OR SUPPLIER INFORMATION			
Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Date First Consulted You For This Condition	Patient ever had same or similar symptoms ? ☐ Yes ☐ No	Dates of Total Disability From Through	Dates of Partial Disability From Through
Name of Referring Physician	For Services Related to Hospitalization Give Hospitalization Dates ADMITTED DISCHARGED			
Name & Address of Facility Where Services Rendered (If other than home or office)	Was Laboratory Work Performed Outside Your Office ? ☐ Yes ☐ No CHARGES		Date Patient Able to Return to Work	

Diagnosis or Nature of Illness or Injury, **RELATE ICD9 TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE**

1.
2.
3.
4.

Date of Service	Place of Service-*	Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given Procedure Code CPT4 (Explain Unusual Services or Circumstances)	D Diagnosis Code ICD9	Charges	

Signature of Physician or Supplier	Questions 7, 8 & 9 Must Be Answered Under Authority of Law	Total Charge	Amount Paid	Balance Due
Signed Date	7. Your Soc. Sec. No.	8. Physician's or Supplier's Name, Address, Zip Code & Telephone No.		
Your Patient's Account No.	9. Your Employer I.D. No.	I.D. No.		

*PLACE OF SERVICE CODES

1- (H) -INPATIENT HOSPITAL
2- (OH) -OUTPATIENT HOSPITAL
3- (O) -DOCTOR'S OFFICE
4- (H) -PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- NIGHT CARE FACILITY (PSY)
7- (NH) -NURSING HOME
8- (SNF) -SKILLED NURSING FACILITY
9- AMBULANCE
0- (OL) -OTHER LOCATIONS
A- (L) -INDEPENDENT LABORATORY
B- -OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

Bill Checker Program

The Plan's Bill Checker Program gives you the opportunity to share in any savings resulting from errors you detect on your medical bills. Please note that duplicate claims and services not covered under the Plan will not be reviewed under the Bill Checker Program.

Please attach a photocopy of both the initial and revised bills and mail them to:

Andover Service Center
P.O. Box 9016
Andover, MA 01810-0916

Enrollee ID #

Patient Name

Hospital Name

Date of Service

Inpatient: ☐ Yes ☐ No

Outpatient: ☐ Yes ☐ No

Q

R

S

T

U

V

W

X

UniCare State Indemnity Plan
Andover Service Center
P.O. Box 9016
Andover, MA 01810-0916
(800) 442-9300
www.unicarestateplan.com

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